PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING	B. WING		C 06/17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 0 FOREST AVE CHMOND, VA 23226	1 00	1172021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	conducted on 6/14/21 facility was in substar	0-19 Focused Survey was I through 6/17/21. The Initial compliance with 42 CFR Innent for Long-Term Care	F	000			
	6/14/21 through 6/17/ investigated during th VA00051747, VA0005 substantiated with de substantiated with no and VA00051766 wer unrelated deficiencies unsubstantiated. Cor	conducted onsite from /21. Complaints were e survey. VA00051976, 51471and VA00051357 were ficiencies. VA00051300 was deficiencies. VA00051006 re unsubstantiated with s. VA00051390 was rections are required for 3 of 42 CFR Part 483					
F 550 SS=D	196. Of the 199 curre were positive for the 0 sample consisted of 0 closed record reviews Resident Rights/Exer	cise of Rights	F	550			7/28/21
	self-determination, ar access to persons an	ght to a dignified existence, nd communication with and					
ADODATOSY		ty must treat each resident			TITI F		(X6) DATE

07/02/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 06/17/2021
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		00/1//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	resident in a manner promotes maintenant her quality of life, recindividuality. The fact promote the rights of §483.10(a)(2) The fact access to quality car severity of condition, must establish and in practices regarding the provision of services residents regardless §483.10(b) Exercise The resident has the	nity and care for each and in an environment that ce or enhancement of his or cognizing each resident's ility must protect and the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her of the facility and as a citizen	F 5	50		
	resident can exercise interference, coercio from the facility. §483.10(b)(2) The refree of interference, reprisal from the faci rights and to be suppexercise of his or he subpart. This REQUIREMENT by: Based on staff interference of the course it was determined the dignity for one of 12 sample, Resident #	cility must ensure that the e his or her rights without in, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her corted by the facility in the rights as required under this in the rights as required under this in the rights as required under this in the cortex complaint investigation at facility staff failed promote residents in the survey in the facility staff wrapped in the sheet instead of providing a		Westport Rehabilitation and Note Center provides this plan of corwithout admitting or denying the existence of the alleged deficie plan of correction is prepared a executed as evidence to comple	rrection e validity or ncies. The and	

Facility ID: VA0270

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 06/17/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	1 00/	1772021	
				7300 FOREST AVE				
WESTPOR	RT REHABILITATION A	IND NURSING CENTER		RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 550	Continued From pa	ge 2	F 5	550				
	coat/jacket when le appointment.	aving the facility for a doctor's		requirements of participation provide high quality resider care.		to		
	The findings include	e:		Gai G.				
	diagnoses that include hemiplegia [1], prostatic hyperplasion Resident # 1's mosset), a quarterly assessment refered coded Resident # 1 brief interview for mof 0 - 15, five - being cognition for making 1 was coded as recone staff member for the facility's "Program". The facility's "Program". The facility is "Program" is "Program" is "Program". The facility is "Program" is "Program" is "Program" is "Program". The facility is "Program" is "Program" is "Program" is "Program". The facility is "Program" is "Prog	dmitted to the facility with uded but were not limited to: dementia [2] and benign ia [3]. It recent MDS (minimum data sessment with an ARD noce date) of 05/06/2021, as scoring a 5 [five] on the nental status (BIMS) of a score g severely impaired of g daily decisions. Resident # quiring extensive assistance of or activities of daily living. The sess Note dated 04/13/2021 at the shoes, he had no jacket, so a laround him to keep him ne of Licensed Practical Nurse		1. Resident #1 continues facility and dons appropriate when leaving facility for app 2. All residents leaving far appointments/outings have be affected by this alleged practice. Facility has ensur leaving for appointments/outerwaring appropriate outerwaring appropriate outerwaring staff that all resider leaving facility for appointments don appropriate outwo contact family to notify if appointments are nearly appointments and the properties of the properties	te outerwear pointments. acility for the potential deficient red all reside utings are vear. re-educate ants who are nents/outings rear, and also propriate reded. randomly autointments ly times 2 to appropriate cility on ridentified corrected. Quality	al to ents ents o to		
	conducted with CN. 4. CNA #4 was ask of care for a resider appointment. CNA [activities of daily liv washed, clean, hav weather, hair comb make sure they we When asked if they	2:43 p.m., an interview was A [certified nursing assistant] ed to describe the procedure int is leaving the facility for an # 4 stated, "I provide ADL ving] care, make sure they are re proper clothing for the ed and teeth brushed and ren't soiled before leaving." had been assigned to take 1, CNA # 4 stated, "Today was		Assurance committee for a revision x 3 months. 5. Date of compliance wi 2021.	·	,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING		C 06/17/2021
	ROVIDER OR SUPPLIER	1	7	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226	00/1//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 550	my first day taking ca another unit." On 06/15/2021 at 10 conducted with RN [r assistant director of review the progress of the resident progress of the review of the rev	ere of him, I usually work on eregistered nurse] # 3, hursing. RN #3 was asked to note documented above. Ote, RN # 3 was asked if it sident # 1 to leave the facility rapped in a bed sheet. RN easked how Resident # 1 essed, RN # 3 stated, "They given him [Resident #1] a not find something family to bring one." When LPN # 12, RN # 3 stated that railable due to being er issue. Resident's Rights in Nursing I in part, "Quality of Life. The to a dignified existence, noice, communication with, as and services inside and he resident must be fully about care and treatment in that care or treatment that ent's well-being. Each uired to "provide services and maintain the highest, mental and psychosocial sident in accordance with a which is initially prepared, with extent practicable of the t's family or legal	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495227	B. WING		06/1	7/2021
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 00/1	772021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	were made aware of No further informatio Complaint Deficiency References: [1] Also called: Hemi Quadriplegia. Paraly function in part of you something goes wrot pass between your be can be complete or p both sides of your be one area, or it can be information was obta https://medlineplus.g [2] A loss of brain fur diseases. It affects in judgment, and behave obtained from the we https://medlineplus.g [3] An enlarged prosi obtained from the we	the above findings In was provided prior to exit. In plegia, Palsy, Paraplegia, resis is the loss of muscle for body. It happens when the major with the way messages for and muscles. Paralysis for artial. It can occur on one or early. It can also occur in just the widespread This fined from the website: ov/paralysis.html. Inction that occurs with certain memory, thinking, language, resiste: ov/ency/article/000739.htm. Itate. This information was ebsite:	F 55			
F 580 SS=E	statebph.html. Notify of Changes (Ir CFR(s): 483.10(g)(14) §483.10(g)(14) Notifi (i) A facility must imm consult with the residuence consistent with his or representative(s) wh	cation of Changes. nediately inform the resident; lent's physician; and notify, her authority, the resident	F 58		7	7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 06/17/2021
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		00/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 5	F 5	80		
	results in injury and physician intervention (B) A significant characteristic (B) A significant characteristic (B) A significant characteristic (C) A need to alter to a need to discontinut treatment due to addition (C) A decision to transident from the fastas. 15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatic available and prophysician. (iii) The facility must resident and the rest when there is- (A) A change in root as specified in §483 (B) A change in resistate law or regulate (e)(10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a comthat is a composite §483.5) must disclosits physical configur	has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lith, mental, or psychosocial hreatening conditions or as); reatment significantly (that is, as an existing form of verse consequences, or to form of treatment); or ansfer or discharge the cility as specified in contification under paragraph (g) and, the facility must ensure that attion specified in §483.15(c)(2) wided upon request to the status promptly notify the sident representative, if any, and or roommate assignment as 10(e)(6); or dent rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and				

PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ľ	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 06/17/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/11/2021	\neg
				7300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	1
F 580	Continued From page	€ 6	F 5	80			
	room changes between under §483.15(c)(9).	y the policies that apply to en its different locations is not met as evidenced					
	Based on staff interver review, clinical record a complaint investigathe facility staff failed and/or responsible parand/or information, for survey sample; Resident #4 min medication Octreotide the prescribed medication Octreotide and times that were retrieved the physician. 1. C. The facility staff order for administering the corder of the physician.	e and a delay in receiving ation. d to consult and obtain cian to administer the e to Resident #4 at intervals not scheduled/approved by failed to consult, obtain an g the medication Octreotide		1. Resident #4 no longer resident facility. The physician of resident been notified of missed treatmer RP of resident #2 has been man of all future appointments. 2. All residents have the potent affected by this alleged deficient 3. DON or designee will educe nurses that missed medication treatments, delay in medication administration due to availability change in delivery method or administration times of medicat require notification of physician clerks will be educated that all appointments, whether made by not, require notification and corwith RP of residents. 4. DON or designee will randomedication orders and related Meekly times 4 weeks and mor	nt #10 hatent. The de aware ntial to be at practice attent all doses or y, need for ions. Ward y facility offirmation omly aud MARs	e e e e or or	
	via a route that was nand failed to notify the medication was not a and by a RN [register 2. The facility staff fathat wound care was 6/13/21 for Resident 3. The facility staff fathat was a facility staff fathat would care was 6/13/21 for Resident staff fathat was a facility staff fathat was a facility staff fathat was a facility staff fathat was not a facility staff fathat was n	not ordered by the physician e physician when the dministered via the route red nurse] as ordered. illed to notify the physician not provided as ordered on		2 to ensure medication is admir ordered, at correct times, and be appropriate staff. DON or design randomly audit MARs/TARs we weeks and monthly times 2 to physicians were notified if a metreatment was missed/delayed. identified issues will be immedicated. Results will be reported. Results will be reported and revision x 3 months. 5. Date of compliance will be	nistered a by inee will ekly time o ensure edication Any ately ted to or analys	es or	

Facility ID: VA0270

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 06/17/2021
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	•	00/1//2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 7	F 5	80		
	2/24/21 and dischar had the diagnoses of obstruction, peritoned diabetes, morbid obstruction places. The Data Set) was an Adard (Assessment of The resident was contract in ability to ma resident was coded eating; extensive as	as admitted to the facility on ged on 3/24/21. The resident of but not limited to intestinal eal adhesions, anal cancer, esity, diverticulosis, and high e most recent MDS (Minimum dmission assessment with an Reference Date) of 3/2/21. Oded as being cognitively ake daily life decisions. The as requiring total care for sistance for transfers, and bathing; and limited				
	discharge documen documented, "Start medicationsOctre (micrograms per mil (milliliter) by intravel daily for 30 days" Note: The resident A review of the phys following: On 2/24/21: "Octree	taking these sotide (1) 100 mcg/ml liliter) injection. 1 ml mous (IV) route three times thad a PICC (2) line IV site. Sician's orders revealed the otide Acetate Solution 100 intravenously three times a				
	On 3/1/21: "Octreo	tide Acetate Solution 100				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		,	C 06/17/2021
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		0/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	day for cancer (RN change from the or that an RN (Registe the medication. The (Licensed Practical the medication.) On 3/4/21: "Octred MCG/ML Use 1 ml day for GI Fistula (I change from the prof diagnosis as to vigiven. On 3/13/21: Octred MCG/ML Use 1 ml day for GI Fistula (I SQ (subcutaneous) The only change from the prof diagnosis as to vigiven. A review of the facil Pass Times" list, the medications was done PM, and 10:00 PM. A review of the pharevealed the medic facility until 2/25/21 documented as an A review of addition revealed two more 3/23/21. No time of these two manifests.	intravenously three times a to administer)." The only iginal order was the addition ered Nurse) had to administer is meant that an LPN Nurse) could not administer outde Acetate Solution 100 intravenously three times a RN to administer)." The only evious order was the change why the medication was being outde Acetate Solution 100 intravenously three times a RN to administer) MAY GIVE of PER (name of physician). The only evious order was the outdenance of the medication via e. It is "Standard Medication e schedule for "TID" ocumented as 6:00 AM, 2:00 or macy manifest document ation was not delivered to the at 11:00 AM and was	F 58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 06/17/2021
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		0071172021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	Director of Pharmac deliveries were (1) r delivered on 3/10/2 3/23/21 and delivered. A review of the MAF the following: The r scheduled for admir and 10:00 PM daily. The February 2021 medication was not On 2/24/21 at 10:00 notes documented. On 2/25/21 at 6:00 notes documented. However, as the medication was administered at available to be adm. On 2/26/21 at 6:00 notes documented, However, as the medication was not on 2/26/21 at 6:00 notes documented, However, as the medication was not evidentified of any of the in receiving the medication on 5 occasions, on 6:00 AM and 10:00	ey. She stated that these 2 equested on 3/10/21 and 1, and (2) requested on ed on 3/23/21. R for February 2021 revealed medication was initially histration at 6:00 AM, 2:00 PM MAR documented that the administered as follows: PM. A review of the nurse's awaiting on pharmacy." AM. A review of the nurse's medication on order." PM. A review of the nurses "awaiting prior authorization." edication was delivered at 2:00 PM, it therefore was inistered at 10:00 PM. AM. A review of the nurse's "pending pharmacy deliver." edication was delivered at 1, it was available to be	F 5	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING_			C 06/17/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		10/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 580	not given for some redocumenting this addraward there were no support regarding this admin. On 6/16/21 at 11:44 #4, the facility's medithe medication was reancer, but was ordesymptoms related to which was in turn reliperitoneal adhesions. On 6/16/21 at 4:28 F#2, (Administrative Since Nursing, she stated the determine if they gaw what does holes on the "If it was not docume administered." There was no evident of these missed doses. On 3/8/21 at 6:00 AM documented as not a nurse's notes documented as not a nurse's	d was not documented as eason. The spot for ministration was left blank. orting nurses' notes istration. AM in an interview with ASM cal director, he stated that not being administered for ered to treat the resident's GI a recently acquired ostomy, ated to intestinal obstruction, and anal cancer. M in an interview with ASM taff Member), the Director of that "If there are holes I can't re it are not." When asked the MAR mean, she stated, it was not to the physician was notified es. M the medication was administered. Supporting ented, "on order."	F 5	80			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495227	B. WING			C 06/17/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	<u> </u>	00/11//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pag	e 11	F 58	30		
	documented as not a	M the medication was administered. Supporting nented, "Awaiting pharmacy."				
	manifest review and reorder was requested on 3/10/21 (per intermanifest). The above that there was a delamedication as nurse order" on 3/8/21, 3/9 not been reordered,	ove documented pharmacy interview with OSM #15, a ed on 3/10/21 and delivered view) or 3/11/21 (per re documentation reflected ay in the facility reordering the s documented it was "on red and 3/10/21 when it had and there was no evidence of otified when the facility did not to administer.				
	orders from the phys	ed to consult and obtain sician to administer the ent #4 at intervals and times uled/approved by the				
	1	nes" list, the schedule for as documented as 6:00 AM,				
	3/4/21 to reflect a ch However, a review o March 2021 revealed additional administra MAR on this date, th on 3/13/21. The Ma additional administra medication could be	order was changed on ange in diagnosis, only. f Resident #4's MAR for d that with this change, tion times were added to the rough the next order change rch 2021 MAR documented tion times that this administered as: 6:00 AM, 8:00 PM and 10:00 PM.				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C 06/17/2021	
		495227	B. WING		,		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226		0/1//2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	that even with 5 pos administration of the never received more on any given day. On 3/11/21 the 6:00 as administered. He administration note and documented, "n RN administration p clinical record failed approving this time was notified of a time the medication. On 3/12/21 the med being administered 8:00 PM. Review of evidence a physicial medication at these with the facility's pol AM, 2:00 PM and 10 times a day, which was being 6:00 AM, 2 facility policy. On 6/16/21 at 12:05 entered this order, sadditional times to a schedule. There was	ge 12 March 2021 MAR revealed sible times available for medication, the resident than the 3 doses as ordered AM dose was documented owever the supporting was documented at 4:42 AM medication times adjusted for er order." Review of the to evidence an order change or that the physician e change in administration of ication was documented as at 10:00 AM, 2:00 PM and the clinical record failed to morder to administer the times and were not in line icy of a TID schedule of 6:00 0:00 PM. The order was for 3 was previously documented :00 PM and 10:00 PM per PM, LPN #5, who had tated that she added the ccommodate the RN's is no documentation ed schedule change by the	F 5				
	#2, she stated that t times a day) medica and 10:00 PM. ASM	AM in an interview with ASM he facility schedule for TID (3 tions was 6:00 AM, 2:00 PM, #2 the director of nursing) schedule with additional					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	· · ·	00/1//2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	and that staff canno administer a medica not ok for the staff to times to reflect a sol spaced without a ph accommodate the Resident." There was no evide made aware of or or allowed for additional staff to pick and choost the medication. As documented abord changed to reflect the administered via the only change in the only change in the only change administer of Resident #4's Madocumented new accommodate the was no evide. There was no evide.	added was not acceptable t pick and choose when to tion." ASM #2 stated, "It was a arbitrarily change these nedule that was not equally sysician's order and to this schedule and not the the that the physician was redered the time changes or al administration times for ose which times to administer and the medication may also subcutaneous injection as the order. Again, this order did tration times. However review arch 2021 MAR revealed defininistration times of 10:00	F 5	80			
	Review of Resident revealed that the do between the 3/13/2	#4's March 2021 MAR ses that were administered 1 10:00 PM dose and 3/24/21 administered per this le change.					
	in an interview with a facility schedule for	nented, on 6/17/21 at 9:32 AM ASM #2, she stated that the TID (3 times a day) 00 AM, 2:00 PM, and 10:00					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		06/17/2021		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		0071772021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	staff to arbitrarily cheschedule that was rephysician's order to schedule and not the line addition Resident not provide any methe medication was administration. It can be to see that was administered via Stroute. 1. C. The facility state order for administer via a route that was and failed to notify medication was not and by a RN [regist A review of Resider 2021 MAR revealed The resident actual of the medication, were administered in the schedule of the sc	at that "it was not ok for the sange these times to reflect a not equally spaced without a accommodate the RN's he resident." It #4's March 2021 MAR did ans to document which route provided at each could not be determined which redication was administered via a first any, the medication was Q, as it was ordered for either aff failed to consult, obtain an ring the medication Octreotide anot ordered by the physician the physician when the administered via the route ered nurse] as ordered. It #4's February and March at the following: Ity received a total of 64 doses Of these 64 opportunities, 41	F 58	,			
	conducted with LPN administered the m times it was adminiasked if she was ar When asked if she was allowed to adm	N #2, who was the LPN that edication on 15 of the 41 stered by an LPN. When N RN, LPN #2 stated, "No." was aware that only an RN ninister the medication, given cian's order, she stated that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	I	33/11/2321	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From paç	ge 15	F 5	80			
	when she looked up book documented the (intramuscularly), so instead of IV, as she could not give a measked if she called the could be given IM at stated she had not. Understanding (from could be given both minutes. Every time When asked about a daministering this may was not provided an administering this may I was not familiar will medication was provided.	edication, she stated that of the medication, the drug hat it could be given IM of she administered it IM of she and IPN and an LPN dication via IV route. When the physician to clarify if it and get an order for IM, she LPN #2 stated, "From my or reading the drug book), it ways. I gave it IM over 3 of I gave it, I gave it IM." of leducation and training for redication, she stated that she hay training or education for redication, but that "It was one th." When asked how the wided by the pharmacy, LPN d in a vial. It did not need to					
	conducted with OSN Pharmacy. She sta any implications for There is no safety is not as effective as I ^N On 6/16/21 at 11:44 #4, the Medical Dire	PM an interview was M #15, the Director of ted that she "Could not find giving the medication IM. ssues. However, given IM it is V or SQ." AM in an interview with ASM actor, he stated that this er been used in this facility					
	#2, she stated that so other LPNs who adm it (IV or IM or SQ).	PM in an interview with ASM she did not know how all the ministered this medication did ASM #2 stated that "There ate and time unknown) where					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		00/11/2021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 580	Continued From pa	ge 16 fied and the nurse obtained an	F 5	580				
	was awaiting a stat [which was never p However, no orders stated that the phys aware of all the oth It was also noted the not provide any me the medication Octa administration, when 3/13/21 to administ be determined which was administered with the medication was between 3/13/21 arfor either route, but had to administer in the medication was	IM." ASM #2 stated, "She ement from the physician rovided by the end of survey]. It is ever reflected this." ASM #2 sician should have been made er times. In the March 2021 MAR did ans to document which route rectide was provided at each en the order was changed on er via IV or SQ. It could not be times, if any, the medication ria IV, and which times, if any, administered via SQ, and 3/24/21, as it was ordered, the order documented an RN medication. Of the 31 times administered after this order through 3/24/21 allowing for						
	either an IV or SQ in the medication 23 the medication 23 the Areview of the facion Nursing Drug Refer 948-950, the information documented that the state of the	route, an LPN administered imes. lity's drug book, "Mosby's 2020 rence, 33rd Edition" pages nation on this medication e IV push route was to be						
	documented for add document it had to route documented, provided, give in glu sites." This was no pharmacy or ordered In total, 15 different	Is minutes. The information ministering via IM route did not be over 3 minutes. The IM "Reconstitute with diluent uteal region, rotate injection of the form provided by the ed by the physician. ILPN's administered this to 9 of which were identified as						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 06/17/2021	
		495227	B. WING _				
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STAT 7300 FOREST AVE RICHMOND, VA 23226	TE, ZIP CODE	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	I	(X5) COMPLETION DATE
F 580	notified that LPNs we medication instead of one LPN (LPN #2) alt administration to IM voccasions. A review of the facility Notifying Physicians of documented, "Non Situations:3. Other have not affected an mental condition." A review of the facility Medications" docume administered in a safe prescribed1. Only permitted by this state document the administed os o3. Medication accordance with the or required time frames. administering the medication from the medication17. For or otherwise unavailate the pass, the MAR medication18. If a given at a time other individual administering in the medication18. If a given at a time other individual administering in the medication at a time other individual administerior individual administerior in the medication administerior individual administerior individual administerior individual administerior in the medication in the medication and the medication administerior individual administerior individual administerior in the medication administerior individual indiv	ce that the physician was re administering the an RN, and that at least tered the route of without an order on 15 y policy, "Guidelines for of Clinical Problems" Immediate Notificationc. Medication errors that individual's physical or y policy, "Administering ented, "Medications shall be and timely manner, and as persons licensed or a to prepare, administer and estration of medications may is must be administered in orders, including any	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED		
	495227	B. WING		C 06/17/2021		
	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 00/1//2021		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
A review of the facility is special Situations - documented, "Media the nursing facility in dispensing from the situation may be dutemporarily out of st drug recall, manufacing redient, or the situation sare available. A. T Call or notify nursing product(s) is/are unshall: 1) Notify the assituation and explaine expected availability are available. a. If the obtain a response from the nurse should now and contact the facing and/or direction. 2) cancel/discontinue to medications. 3) Not replacement order. The survey. Complaint Deficience References: (1) A review of the face 2020 Nursing Drug pages 948-950, October 19 decivers of the face 2020 Nursing Drug pages 948-950, October 2020 Note	ty policy, "Miscellaneous Unavailable Medications" cations used by residents in may be unavailable for pharmacy on occasion. This e to the pharmacy being ock of a particular product, a cturer's shortage of an uation may be permanent no longer being made. The very effort to ensure that ailable to meet the needs of the pharmacy staff shall: 1) g staff that the ordered availableB. Nursing staff ttending physician of the nother circumstances, and optional therapy(ies) that the facility nurse is unable to foom the attending physician, tify the nursing supervisor lity Medical Director for orders Obtain a new order and the order for the non-available tify the pharmacy of the on was provided by the end of the e	F 58				
	OVIDER OR SUPPLIER T REHABILITATION AI SUMMARY S (EACH DEFICIEN REGULATORY OF) Continued From page A review of the facility of the nursing facility in dispensing from the situation may be due temporarily out of st drug recall, manufacting facility must make e medications are available, and a situation and explain expected availability are available. a. If the obtain a response from the nurse should no and contact the facility are available. a. If the obtain a response from the nurse should no and contact the facility are available. The n	OVIDER OR SUPPLIER T REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 A review of the facility policy, "Miscellaneous Special Situations - Unavailable Medications" documented, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is/are unavailableB. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medications. 3) Notify the pharmacy of the replacement order." No further information was provided by the end of the survey. Complaint Deficiency	OVIDER OR SUPPLIER T REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 A review of the facility policy, "Miscellaneous Special Situations - Unavailable Medications" documented, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is/are unavailableB. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medications. 3) Notify the pharmacy of the replacement order." No further information was provided by the end of the survey. Complaint Deficiency References: (1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for symptoms of carcinoid tumors, vasoactive	OVIDER OR SUPPLIER TREHABILITATION AND NURSING CENTER TREHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC. IDENTIFYING INFORMATION) Continued From page 18 A review of the facility policy, "Miscellaneous Special Situations - Unavailable Medications" documented, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is fare unavailableB. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available to a stending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medications. 3) Notify the pharmacy of the replacement order." No further information was provided by the end of the survey. Complaint Deficiency References: (1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octroolide was used for symptoms of carcinoid tumors, vasoactive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		33/11/2321	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	fistulas, diarrheal or syndrome. The information obtained that the administered over 3 medication was doorefrigerator for unoptemperature up to 2 Multiple side effects diarrhea. Interaction of insulin which requevels. (2) PICC - A periph (PICC), also called tube that's inserted and passed through heart. Very rarely, the large central vergenerally used to gruntrition. A PICC limit frequent needle stick irritation to the sma PICC line requires a complications, includinformation obtained.	uding GI (gastrointestinal) conditions, and dumping cormation on this medication the IV push route was to be the minutes. Storage of this commented as storage in the commented vials or at room the weeks, protected from light. It was documented, including the instructions of glucose the area of the place of the plac	F 5	80			
		failed to notify the physician as not provided as ordered on at #10.					
	3/28/12, with the discerebrovascular dis	admitted to the facility on agnoses of but not limited to ease, stroke, contracture, nentia, depression, high blood					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 06/17/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI 7300 FOREST AVE RICHMOND, VA 23226	E, ZIP CODE	00/1//2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENCI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 580	pressure, atrial fibrill degeneration. The r Data Set) assessme with an ARD (Assess 4/12/21, coded Resimpaired in ability to The resident was coassistance for all are except for eating, whonly. A review of the clinic note dated 6/11/21 tiln Condition:Skin some excoriation no Primary Care Provid Recommendations: to both areas and codressing" Further review reveatacility's wound care evaluation documen 1.39 cm Depth 0.1 Ulcer - Stage 2Drusecondary Dressing A review of the clinic physician's order data buttocks cleanse wit medihoney, cover with the document of the docum	ation, and lumbar disc nost recent MDS (Minimum nt, a quarterly assessment sment Reference Date) of dent #10 as moderately make daily life decisions. ded as requiring extensive eas of activities of daily living, nich required supervision al record revealed a nurse's nat documented, "Change wound or ulcerSacrum has ted to bilateral sacrum. er FeedbackA. Metta (sic) honey (1) applied over with a bordered gauze alled an evaluation from the provider dated 6/11/21. This ted, "Length: 1.37 cm. Width 10 cmEtiology: Pressure essings: Medihoney Bordered gauze" al record revealed a ted 6/11/21 for "Bilateral th NS (normal saline), apply th boarder gauze" 2021 TAR (Treatment rd) revealed this treatment d as being completed on	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED	
		495227	B. WING		C 06/17/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	00/1//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETION
F 580	#10 on 6/13/21. Wh wound care on 6/13/do the wound care. day. I had three hos family here. I didn't ger itI did not do the if she notified anyone supervisor, the next did not notify anyone done." When asked notified, LPN #3 state. A review of the comprevealed one dated alteration in skin interincluded an intervent "Treatment as ordered." Treatment as ordered. A review of the facilit documented, "Report if the resident refuse other information in a and professional state. A review of the facilit Notifying Physicians documented, "Nor Situations:3. Othe have not affected an mental condition." On 6/15/21 at 4:34 F (Administrative Staff and Director of Nursiaware of the findings.	to was assigned to Resident en asked if she did the 21, LPN #3 stated, "I did not at was a really, really busy pice residents and a lot of get to it. I don't believe I tried e wound care." When asked e (the physician, nurse shift nurse) LPN #3 stated, "I that the wound care was not if anyone should have been ed, "Yes." The rehensive care plan and the form of a trisk for grity" This care plan and the form of a trisk for grity" This care plan and the form of a trisk for grity" The policy, "Wound Care" the form of a trisk for grity" The care plan and the form of a trisk for grity" The policy, "Wound Care" the form of a trisk for grity" The policy, "Guidelines for the form of Clinical Problems" and the form of Clinical Problems and the form of th	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING_			C 06/17/2021		
	ROVIDER OR SUPPLIER	11		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		10/11/2021		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page the survey.	e 22	F 5	580				
	References:							
	contains 100% active hydrocolloidal susper of necrotic tissue and Thicker consistency t provides more stabilit Information obtained	, from urce.com/product/medihone						
		iled to notify Resident # 2's urology appointment on						
	diagnoses that includ	nitted to the facility with ed but were not limited to: s [1], legal blindness, vision atic hyperplasia [2].						
	set) assessment, an an ARD (assessment 04/21/2021, coded Resiz) on the brief inter (BIMS) of a score of 0 impaired of cognition Resident # 2 was codassistance of one standaily living.	esident # 2 as scoring a 6 view for mental status 0 - 15, six - being severely for making daily decisions. led as requiring extensive ff member for activities of						
		Facility Transfer Report" for 4/15/2021 from [Name of						

PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING	B. WING		C 06/17/2021		
	ROVIDER OR SUPPLIER	ND NURSING CENTER	1	7	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE CICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Information. Follow of Go on 4/22/2021 at The facility's unit 2 d part, "Friday, April 16. 202 Resident # 2] on 4-2 "Thursday, April 22. / 2:30pm [Urology O Transport Company The [Name of Urolog 2 dated 04/22/2021 # 2's past medical himpressions indicating the urologist on 04/2 On 06/14/2021 at 1: conducted with OSM social worker regard unaccompanied to the left in the doctor's of When asked to described.	ed in part, "Follow-up up with [Name] of Urology. 2:30 pm [Name of Doctor]." lesk calendar documented in 21. Transport [Name of 2-21." 2021. [Name of Resident # 2] ffice Address. Name of l.] P/u [pick up] 1:30 [p.m.]." gy] office note for Resident # documented in part Resident listory, urinalysis results and ling Resident # 2 was seen by	F	580	DEFICIENCY			
	set, someone from t [responsible party] a accompany the resid 2, OSM # 2 stated, " already there. The t [facility] and said he seen because no on what I understand the group home did show On 06/15/2021 at 12 conducted with ASM	ted, "After the appointment is he unit will contact the RP and ask who going to dent." In regard to Resident # I was brought in after he was urology office called us [Resident # 2] couldn't be e was there with him. From the case manager from the w up at the urology office." 2:42 an interview was I [administrative staff or of nursing regarding the						

Facility ID: VA0270

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	E	33/1//2321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 580	for an appointment. the doctor's office for RP [responsible parthey are responsible assistance, if the RF attend [the appointmember and the traithe ward clerks." Wresponsible for the rand the doctor's office accompanying the retransport company. we don't make the atthe RP." On 06/15/2021 at 3: conducted with CNA 8, ward clerk for unit to describe the processive who have appointment contacted if they arrang Resident # 2's urolo CNA # 8 stated yes. contacted Resident appointment CNA # On 6/16/2021 at 8:0 conducted with LPN 5, nurse manager for the notification of Resident the supervision appointment on 04/2 describe the process scheduled for an outstated, "If the reside through the orders as a series of the orders are series of the orde	g a resident out of the facility ASM # 2 stated, "We call or the appointment, notify the ty] of the appointment and e if the resident needs of states that they cannot ment] we will try to send a staff insportation gets arranged by then asked who was resident between the facility receif there is no one resident, ASM # 2 stated the ASM # 2 further stated, "If reppointment we don't contact 51 p.m., an interview was a [certified nursing assistant] # the number two. When asked residents CNA # 8 stated, "I set up reappointments." When red the transportation for gy appointment on 4/22/2021 When asked if they # 2's RP about the 8 stated no. 8 a.m. an interview was I [licensed practical nurse] # reform unit number two, regarding resident # 2's responsible party of Resident # 2 for a urology 22/2021. When asked to sticle appointment, LPN # 5 nt is a new admission I go	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
			7 501251	_		(2
		495227	B. WING			06/	17/2021
	ROVIDER OR SUPPLIER	ND NURSING CENTER		7:	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE IICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	the calendar as a reitime to set up transpalready here and it is appointment I do the calendar for the ward seven days on the cward clerk has time also call the RP [resknow when and whe appointment is and a transport the resider transportation. I also to the appointment, I the resident at the adescribe the procedunable to meet the reLPN # 5 stated, "I coassistant) # 3], scheet of free up to go to the been able to do it a fasked about docume was contact prior to stated that it would be progress notes. LPN progress notes for R through 04/30/2021. LPN # 5 stated, "The about contacting the concern that Reside urology appointment unaccompanied, LPI have been contacted met the resident at the The facility's policy."	pack five to seven days on minder so the ward clerk has ortation. If the resident is a new order for an a same thing, put it on my diclerk and I go back five to alendar as a reminder so the to set up transportation. I ponsible party] and let them are the scheduled ask them if they want to at or have us set up to ask the RP if they are going most of the time they meet oppointment." When asked to bure followed when the RP is a sesident at the appointment, antact [CNA (certified nursing duler, to see if they have see the appointment, they have see the witnes in the past." When an appointment, LPN # 5 are documented in the N # 5 was asked to review the an appointment in the N # 5 was asked to review the esident # 2 dated 04/15/2021 After reviewing the notes, are's nothing documented RP." When informed of the note it and left in the doctor's office N # 5 stated, "The RP should do and someone should have the office."	F	580			
	assist residents in ar	r Statement: Our facility will rranging transportation s when necessary. Policy					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		C 06/47/2024
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	06/17/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 580 F 607 SS=D	Interpretation and Implecome necessary to appointment outside it Service Designee or the resident's representative (sponstransporting the residappointment. 3. Shouthe facility to provide Service Designee will arranging the transporting to the transporting to the transporting to the transporting to the transporting the transporting to	colementation: 1. Should it transport a resident to an the facility, the Social Charge Nurse shall notify entative (sponsor) and informment. 2. The resident's cor) will be responsible for ent to his or her all dit become necessary for transportation, the Social be responsible for entation through the business or transportation should be ce as possible. 5. The use port residents to be approved by the coroximately 10:15 a.m., ASM nember] # 1, the coroximately 10:15 a.m., as we have provided prior to exit. Social buse/Neglect Policies and procedures that: It and prevent abuse, ion of residents and esident property, she policies and procedures	F 580		7/28/21

PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				C 17/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226	1 00	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 607	by: Based on staff interview, clinical record a complaint investigathe facility staff failed abuse policy to report of abuse to the state residents in the survey facility staff failed to allegations of abuse therapy staff on 12/7 The findings include: Resident #9 was adma 8/31/20, and most record 10/12/20, with diagnote HIV (human immulanoxic brain injury (2) the most recent MDS assessment, a quarte 3/10/21, Resident #9 cognitive impairment having scored 15 out interview for mental substitution of the facility and Reporting," reversident abuse, negli reported to local, stafagenciesand thorosides.	riew, facility document dereview, and in the course of ation, it was determined that to implement the facility and investigate allegations agency for one of 12 by sample, Resident #9. The report and investigate two made by Resident #9 to //20 and 2/19/21. Initted to the facility on cently readmitted on oneses including, but not limited nodeficiency virus) (1), and quadriplegia (3). On the control of the con	F	607	1. Resident #9 continues to reside in facility. His reported grievances have been reported and investigated. 2. All residents have the potential to affected by this alleged deficient practic 3. DON or designee will educate all son types of abuse, responsibility to rep immediately, but not later than 2 hours after the allegation is made. Facility administrator, DON and social workers will be educated on conducting comple and thorough investigation of all allegations of abuse. 4. Administrator or designee will randomly audit grievances weekly time weeks and monthly times 2 to ensure than any grievances alleging abuse have be reported and investigated timely. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analy and revision x 3 months. 5. Date of compliance will be July 28 2021.	be ce. staff ort te	

Facility ID: VA0270

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021		
	IDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	CODE	00,11,20	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	COMP	X5) PLETION ATE	
in fa fo lic si vi la in in vi la	cility Administrator, illowing persons or a sensing/certification urveying/licensing the olationwill be reporter than a. Two house abuse OR has jury; or b. Twenty-foolation does not invested in serious bout a concern reporter ember) #14)], PTA (seistant)Describe ember) #14)], PTA (seistant) whom the difference of the seistant) when the 3 to 11:00 p.m. NA 'is rough with meanily living)/reposition presponsive to his resigned to take actions are seisigned to take actions	ectwill be reported by the or his/her designee, to the agencies: The state agency responsible for he facilityAn alleged by the difference of the alleged of the alleg	F	507				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 06/17/2021			
	ROVIDER OR SUPPLIER			STREET ADDREST RICHMOND,		1 06/1	1772021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 607	Continued From page	29	F	607					
	The DON at the time submissions was no I facility.	of these grievance onger employed at the							
	allegation of abuse to grievance form right a form is a facility form. we need to report it w stated if it was an alle notify the social work some examples of abpushing, or anything malicious. When aske a type of abuse, OSM shown the above refedated 12/7/20, OSM specifically remember Resident #9. He state allegation abuse; he sneglect. When asked OSM #14 stated he pmore specific. He state referred to the resider and there was no indimalicious in his action him that when the resident with him, the office the state this concern. When a dependencies, OSM hypoxic-induced quad lower extremities, and upper extremities. He	dif a resident reports an him, he would fill out a away. OSM #14 stated the OSM #14 stated, "I think iithin a couple of hours." He gation of abuse, he would er. When asked to give use, he stated hitting, that is physical and ed if failure to provide care is 1 #14 stated it is. When arenced grievance form 4 #14 stated he did not are the conversation with ed he would not consider this estated he would consider it about the 2/19/21 form, robably should have been ted the term 'rough with me' and being 'turned too hard,' cation that the CNA was and. He stated the resident told dident asked the CNA to be CNA was not responsive to do the DON was informed of sked about the resident has driplegia, no control of his stated the resident is staff to help him with all							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.25			(С
		495227	B. WING			06/	17/2021
	ROVIDER OR SUPPLIER RT REHABILITATION A	ND NURSING CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	staff member) #2, the regional director of interviewed. ASM # the information conting grievance forms to be resident and try to get stated she would try circumstances, and members who were ASM #2 stated she the resident meant on those findings, if issue, she would not investigate further. With this. ASM #2 we should be reported stated, "If a resident of abuse." ASM #2 we should be reported stated, "If a resident of abuse." ASM #2 hours to report an agency. When show ASM #2 stated this investigated immed hours. When shown ASM #2 stated this investigated and repabuse or neglect. A regional, I was not a have been reported. On 6/16/21 at 5:15 administrator, and A these concerns. AS employed in his cur and was not working.	p.m., ASM (administrative ne DON, and ASM #3, the clinical services, were 2 stated if anyone reported rained in the above referenced ner, she would interview the retermore information. She was to track down the identify the particular staff mentioned by the resident. would try to determine what by 'rough.' She stated based she thought there was an extify the administrator and ASM #3 stated she agreed has asked if these concerns to the state agency, ASM #2 tis being harmed or any type d, "If the resident says he entionally treated, I would say 2 stated the facility has two allegation of abuse to the state with the 12/7/20 grievance form, should have been intelligent and reported within two at the 2/19/21 grievance form, also should have been corted as an allegation of SM #3 stated, "As the aware of thisThis should."	F	607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 06/17/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		50/17/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607		e 31 n was provided prior to exit.	F 60	07		
	References:					
	AIDS is the most adv infection." This inform website	hat causes HIV infection. anced stage of HIV nation is taken from the //understanding-hiv/fact-shee				
	brain injury, is a proc cessation of cerebral which most common is the case, for exam poisoning or drug ove insult, or cardiac arre- from the website	opathy, or hypoxic-ischemic ess that begins with the blood flow to brain tissue, y results from poisoning, as ple with carbon monoxide erdose, vascular injury or st." This information is taken .nih.gov/books/NBK539833/.				
F 609 SS=D	brain injury, is a proc cessation of cerebral which most common is the case, for exam poisoning or drug ove insult, or cardiac arre- from the website https://www.ncbi.nlm Reporting of Alleged		F 6	09		7/28/21
	, , ,	se to allegations of abuse, or mistreatment, the facility				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		C 06/17/2021		
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	00/11/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 609	involving abuse, negli mistreatment, includir source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not resist the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the additional designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on staff interview, clinical record a complaint investigation of allegations and failed to officials and failed to officials and failed to	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, itely, but not later than 2 tion is made, if the events cion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established	F 60	1. Resident #9 continues to reside in facility. His reported grievances have been reported and investigated. 2. All residents have the potential to affected by this alleged deficient praction types of abuse, responsibility to repimmediately, but not later than 2 hours after the allegation is made. Facility administrator, DON and social workers will be educated on conducting compleand thorough investigation of all allegations of abuse.	be ce. staff ort		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			06/17/2021		
NAME OF PROVI	DER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	11/2021	
				73	00 FOREST AVE			
WESTPORTR	EHABILITATION AN	ID NURSING CENTER		RI	ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
Res 8/3 100 to an the que co man 15 Mic Res de A I #9 me as ter ab state co nu ide "2/49 co 'no nu on Ch da	31/20, and most re /12/20, with diagn HIV (human immuoxic brain injury (2 e most recent MDS arterly assessmer ded as having no aking daily decisio on the BIMS (briedliple attempts we esident #9 during to clined to be interversely entire to be intervers	mitted to the facility on ecently readmitted on oses including, but not limited inodeficiency virus) (1), 2), and quadriplegia (3). On S (minimum data set), a not dated 3/10/21, he was cognitive impairment for ns, having scored 15 out of eff interview for mental status). The resident interview he survey. The resident interview details are records revealed, in initiating concern[Resident ed to [OSM (other staff (physical therapy concern using factual expressed continued concern ed nursing assistant). Pt the me or clean gnated to take action on this	F	609	4. Administrator or designee will randomly audit grievances weekly time weeks and monthly times 2 to ensure the any grievances alleging abuse have be reported and investigated timely. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analy and revision x 3 months. 5. Date of compliance will be July 28 2021.	hat een sis		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING				C
NAME OF B		493221	B. WING		TREET ARRESTS OFFI THE TIP CORE	06/	17/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	ID NURSING CENTER			300 FOREST AVE LICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 609	Continued From page 34		F (609			
		on on this concern: Given to sing)Results of action e resident."					
	The DON at the time submissions no long	of these grievance er works at the facility.					
	allegation of abuse to grievance form right form is a facility form we need to report it we stated if it was an allo notify the social work some examples of all pushing, or anything malicious. When ask a type of abuse, OSN shown the above reference	ed if a resident reports and be him, he would fill out a away. OSM #14 stated the . OSM #14 stated, "I think within a couple of hours." He egation of abuse, he would ter. When asked to give buse, he stated hitting,					
	Resident #9. He state allegation abuse; he neglect. When asked OSM #14 stated he properties and there was no indicate and the residual to the third properties. He state this concern. When a dependencies, OSM hypoxic-induced quallower extremities, an upper extremities. He	er the conversation with ed he would not consider this stated he would consider it I about the 2/19/21 form, probably should have been ated the term 'rough with me' ent being 'turned too hard,' lication that the CNA was n. He stated the resident told sident asked the CNA to be CNA was not responsive to ed the DON was informed of asked about the resident's #14 stated the resident has driplegia, no control of his d minimal control of his e stated the resident is staff to help him with all					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _		,	C 06/17/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		10/11/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 609	staff member) #2, the regional director of conterviewed. ASM #2 the information contagrievance forms to he resident and try to go stated she would try circumstances, and members who were ASM #2 stated she would members who were ASM #2 stated she would not investigate further. A with this. ASM #2 was should be reported to stated, "If a resident of abuse" She stated feels like he was interested in the stated of abuse." ASM #2 hours to report an all agency. When shown ASM #2 stated this sinvestigated immediations. When shown ASM #2 stated this action was not a shave been reported. A review of the facilities.	aily living). o.m., ASM (administrative e DON, and ASM #3, the elinical services, were elinical services, were elined in the above referenced ained in the above referenced ained in the above referenced arer, she would interview the et more information. She to track down the identify the particular staff mentioned by the resident. would try to determine what by 'rough.' She stated based she thought there was an aiffy the administrator and as M #3 stated she agreed as asked if these concerns to the state agency, ASM #2 is being harmed or any type d, "If the resident says he entionally treated, I would say stated the facility has two legation of abuse to the state on the 12/7/20 grievance form, should have been ately and reported within two the 2/19/21 grievance form, also should have been orted as an allegation of SM #3 stated, "As the ware of thisThis should	F 6	09				
	reported to local, sta	ectshall be promptly ite, and federal oughly investigated by facility						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495227	B. WING		C 06/17/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		6/11//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 609	will also be reported. involving abuse, neg facility Administrator, following persons or licensing/certification surveying/licensing t violationwill be replater than a. Two hou involves abuse OR hinjury; or b. Twenty-fiviolation does not invresulted in serious be On 6/16/21 at 5:15 p administrator, and Atthese concerns. ASM employed in his curre and was not working the grievance concerns. ASM employed in his curre and was not working the grievance concerns. ASM employed in his curre and was not working the grievance concerns. ASM employed in his curre and was not working the grievance concerns. ASM employed in his curre and was not working the grievance concerns. (1) "HIV is the virus to AIDS is the most advinfection." This inform website https://hivinfo.nih.gov ts/hivaids-basics. (2) "Anoxic encephal brain injury, is a processation of cerebra which most common is the case, for exampoisoning or drug ov	gs of abuse investigationsAll alleged violations lectwill be reported by the or his/her designee, to the agencies: The state agency responsible for he facilityAn alleged orted immediately, but not urs if the alleged violation as resulted in serious bodily our hours if the alleged volve abuse AND has not odily injury." .m., ASM #1, the SM #2 were informed of M #1 stated he has only been ent position for a few weeks, at the facility at the time of rns reported by Resident #9. In was provided prior to exit. hat causes HIV infection.	F 60	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 06/17/2021
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	E	00/1//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	
F 655 SS=D	(3) "Anoxic encephale brain injury, is a proceed cessation of cerebral which most commonl is the case, for exampoisoning or drug over insult, or cardiac arrefrom the website https://www.ncbi.nlm. Baseline Care Plan CFR(s): 483.21(a)(1)	opathy, or hypoxic-ischemic ess that begins with the blood flow to brain tissue, y results from poisoning, as ple with carbon monoxide erdose, vascular injury or st." This information is taken .nih.gov/books/NBK539833/.		655		7/28/21
	§483.21(a) Baseline §483.21(a)(1) The facinplement a baseline that includes the instreffective and personthat meet professional The baseline care platicities (i) Be developed with admission. (ii) Include the minimula necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm	cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's um healthcare information y care for a resident ted to- d on admission orders. nendation, if applicable. cility may develop a plan in place of the baseline				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1	C 17/2021
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		, 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From pag (i) Is developed with admission. (ii) Meets the require (b) of this section (e) this section). §483.21(a)(3) The firesident and their reform the baseline care limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services an administered by the on behalf of the facil (iv) Any updated inform the comprehensive This REQUIREMENT by: Based on staff intermined in the facility staff failed plan for one of 12 reform the facility staff failed plan for one of 12 reform the facility staff failed the facility staff failed plan for one of 12 reform the facility staff failed the facility sta	the 38 sin 48 hours of the resident's sements set forth in paragraph (cepting paragraph (b)(2)(i) of acility must provide the presentative with a summary plan that includes but is not of the resident. The resident is medications and described the details and personnel acting ity. The summation based on the details are care plan, as necessary. The is not met as evidenced view, facility document described to develop a baseline care sidents in the survey sample, and to develop a baseline care		655	1. Resident #4 no longer resides in facility. 2. All residents newly admitted to the facility have the potential to be affected this alleged deficient practice. 3. DON or designee will educate all nurses that a baseline care plan must I developed for each resident within 48	l by	
	physician prescribed	nonitoring criteria of the medication Octreotide. (1)			hours of admission to the facility and is separate from the comprehensive care plan, and that the baseline care plan maddress the care to meet the resident immediate needs.	nust Is	
	Baseline" document to meet the resident	ry policy, "Care Plans - ed, "A baseline plan of care s immediate needs shall be resident within forty-eight (48)			4. DON or designee will randomly au baseline care plans weekly times 4 we and monthly times 2 to ensure resident have a baseline care plan present and developed appropriately. Any identified issues will be immediately corrected.	eks ts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING_				C
NAME OF PE	ROVIDER OR SUPPLIER	433221	B: Willo	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	06/	17/2021
TO AME OF TH	TO VIDER OR OUT FEET				600 FOREST AVE		
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER			ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 655	F 655 Continued From page 39		F 65				
	hours of admission."	re plan was maintained at admission as the developed into the plan. They were not			Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28 2021.	,	
	Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) assessment, an admission assessment with an ARD (Assessment Reference Date) of 3/2/21, coded Resident #4 as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene.						
	documented, "Start ta medicationsOctreo (micrograms per millil (milliliter) by intravend daily for 30 days" N	follows: document dated 2/24/21 that aking these tide (1) 100 mcg/ml					
		ide Acetate Solution 100 ravenously three times a					

NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			495227	B. WING			C 06/17/2021	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			1		7300 FOREST AVE	I	00/11/2021	
DEFICIENCY)		(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
On 3/1/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for cancer (RN to administer)." The only change from the original order was the addition that an RN (Registered Nurse) had to administer the medication. This meant that an LPN (Licensed Practical Nurse) could not administer the medication. On 3/4/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI (gastrointestinal) Fistula (RN to administer)." The only change from the previous order was the change of diagnosis as to why the medication was being given. On 3/13/21: Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer) MAY GIVE SQ (subcutaneous) PER (name of physician). The only change from the previous order was the ability to also administer the medication via subcutaneous route. On 6/16/21 at 11.44 AM in an interview with ASM #4, the facility's medical director, he stated that the medication was not being administered for cancer, but was ordered to treat the resident's GI symptoms related to a recently acquired ostomy (which was in turn related to intestinal obstruction, peritoneal adhesions and anal cancer. A review of the February and March 2021 MAR revealed the resident actually received a total of 64 doses of the medication. A review of the clinical record failed to reveal any	F 655	On 3/1/21: "Octreoti MCG/ML Use 1 ml in day for cancer (RN to change from the origi that an RN (Register the medication. This (Licensed Practical Nother medication. On 3/4/21: "Octreoti MCG/ML Use 1 ml in day for GI (gastrointe administer)." The original order was the change medication was being medication was being the only change from ability to also administed subcutaneous route. On 6/16/21 at 11:44 and the facility's meditation was order the medication was order symptoms related to (which was in turn reperitoneal adhesions). A review of the Februare each of the medication was of the facility of the medication was order to the facility of th	de Acetate Solution 100 dravenously three times a padminister)." The only inal order was the addition ed Nurse) had to administer meant that an LPN durse) could not administer de Acetate Solution 100 dravenously three times a estinal) Fistula (RN to nly change from the previous e of diagnosis as to why the g given. de Acetate Solution 100 dravenously three times a N to administer) MAY GIVE PER (name of physician). In the previous order was the ster the medication via AM in an interview with ASM dical director, he stated that not being administered for ered to treat the resident's GI a recently acquired ostomy lated to intestinal obstruction, and anal cancer. Dary and March 2021 MAR t actually received a total of ication.	F 65	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 6/17/2021		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		6/17/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 655	medication, along wadministration and related to the criteria administration, and complications, was on Resident #4's cabaseline care plan or plan. A review of the care One dated 3/12/21, 2/24/21 with the IV scomplications at IV plan only included in site, dressing, and to not include any interest and the administration requirements of the medication Octreotic One dated 2/25/21 sunsteady gait, gene environment, medical Interventions include "Administer medication Octreotic "Administer medication and rephysician prescribed One dated 3/12/21 of 2/24/21 with the ost Ostomy related to desident fondles with the ost of the medication of the physician prescribed of the sident fondles with the ost of the criteria administration and rephysician prescribed of the sident fondles with the ost of the criteria administration and rephysician prescribed of the criteria administration and	ith its associated monitoring requirements a of an RN only associated side effects and ever developed or addressed re plan, either the admission or the comprehensive care I plan revealed the following: (resident was admitted on site in place) for "Potential for insertion site" This care interventions related to the IV ubing management and did reventions related to the use, on and monitoring physician prescribed de. For "At risk for falls due to ralized weakness, new ation side effect." ed one dated 2/25/21 to tion per physician's order." ventions related to the use, monitoring requirements of the dimedication Octreotide. (resident was admitted on comy site in place) for "Bowel isease process cancer th ostomy appliances." The	F 68					
	presence of the osto include any interver the administration a	Octreotide related to the omy. The care plan did not stions related to the use, and not monitoring requirements of ribed medication Octreotide.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY COMPLETED	
		495227	B. WING			C 06/17/2021
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	!	00/11//2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	2/24/21 with a risk distress related to redistress related to result for "Administer mediab results for possinterventions did not related to the use, monitoring requirer. On 6/16/21 at 3:00 conducted with RN QA nurse (Quality A care plan should have the use of any IV medication that have before, which the sthat required specific	(resident was admitted on for GI distress) for "G.I. nausea/vomiting." led interventions dated 3/12/21 dications per physician orders" ications, diet, environment and lible causes." The ot include any interventions and the administration and ments of the Octreotide. PM an interview was #2 (Registered Nurse), the Assurance). RN #2 stated a lave been developed regarding ledication; and for a dinot been used in the facility taff was not familiar with, and fic administration and RN #2 stated there definitely	F 6	55		
	On 6/17/21 at 4:28 PM in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing) she stated that it should have been care planned. ASM #2 stated she reviewed Resident #4's care plan and it was not done. No further information was provided by the end of the survey. References: (1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING		06/1) 17/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 007	1772021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)) BE	(X5) COMPLETION DATE
F 655	symptoms of carcinoi intestinal peptide turn unlabeled uses includifistulas, diarrheal consyndrome. The information documented that the administered over 3 medication was docurefrigerator for unope temperature up to 2 v Multiple side effects v diarrhea. Interactions of insulin which requirelevels. (2) PICC - A peripher (PICC), also called a tube that's inserted thand passed through the large central vein generally used to give nutrition. A PICC line frequent needle sticks irritation to the smalle PICC line requires carcomplications, includit Information obtained	d tumors, vasoactive ors, as well as some ling GI (gastrointestinal) ditions, and dumping mation on this medication IV push route was to be ninutes. Storage of this mented as storage in the ned vials or at room veeks, protected from light. Vas documented, including included decreased effect red monitoring of glucose ally inserted central catheter PICC line, is a long, thin rough a vein in your arm to the larger veins near your PICC line may be placed in gives your doctor access to see near the heart. It's the medications or liquid can help avoid the pain of and reduce the risk of the veins in your arms. A reful care and monitoring for nig infection and blood clots. If from ic.org/tests-procedures/picc-	F 65	5		
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh	comprehensive Care Plan	F 65	6		7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	00/17/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	§483.10(c)(3), that objectives and time medical, nursing, at needs that are iden assessment. The or describe the followi (i) The services that or maintain the resiphysical, mental, ar required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS, rationale in the resicity) In consultation we resident's represent (A) The resident's godesired outcomes. (B) The resident's godesired outcomes. (B) The resident's putture discharge. Fawhether the resider community was assolical contact agence entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT.	orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive comprehensive care plan must ang - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 33.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)- totals for admission and areference and potential for acilities must document at's desire to return to the tessed and any referrals to ties and/or other appropriate	F 6	1. Residents #4 and #5 no l	onger reside		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _				C 17/2021		
	ROVIDER OR SUPPLIER	D NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 656	a complaint investigathe facility staff failed implement the comprof 12 residents in the #4, #10 and #5. 1. The facility staff facomprehensive care administration and m Octreotide (1) for Resident and care to Resident and the diagnoses of obstruction, peritoned diabetes, morbid obe blood pressure. The Data Set) assessment with an ARD (Assess 3/2/21, coded Resident ability to make daily I was coded as requiring extensive assistance.	d review, and in the course of tion, it was determined that to develop and/or ehensive care plan for three survey sample, Residents alled to develop a plan for the use, onitoring criteria of sident #4. silled to implement the plan for the provision of ent #10 on 6/13/21. To implement the plan for the administration of ent #5 as ordered by the and 2/20/21.	F6	656	in facility. The care plan of resident #10 has been reviewed to ensure comprehensive care plan has been developed and implemented. 2. All residents have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses that care plans should be comprehensive to include the provision wound care and the administration of medications, and also must be implemented. 4. DON or designee will randomly aux care plans and related MARs and TARs weekly times 4 weeks and monthly time 2 to ensure that care plans address provision of wound care, medication administration and are being implemented. Any identified issues will immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	bece. of ditses			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _				C 17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 656	A review of the facilic Comprehensive Per "A comprehensive, puthat includes measure timetables to meet a psychosocial and furand implemented for residentAssessmand care plans are in the residents and the change" A review of the clinic physician's orders and the change" A review of the clinic physician's orders and the change medicationsOctree (micrograms per mill (milliliter) by intravered ally for 30 days" PICC [peripherally in line IV [IV [intravence on 2/24/21: "Octree MCG/ML Use 1 ml in day (TID) for cancer (RN to change from the original that an RN (Registe the medication. This (Licensed Practical the medication.	ty policy, Care Plans, son-Centered" documented, person-centered care plan rable objectives and a resident's physical, nctional needs is developed reach ents of residents are ongoing revised as information about the residents' conditions cal record revealed so follows: document dated 2/24/21 that taking these rotide (1) 100 mcg/ml liliter) injection. 1 ml mous (IV) route three times Note: The resident had a reserted central catheter] (2) rous line] site.	F	656				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' ') MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1	C 17/2021	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	F 656 Continued From page 47		F	556				
	administer)." The o	estinal) Fistula (RN to nly change from the previous e of diagnosis as to why the g given.						
	MCG/ML Use 1 ml ir day for GI Fistula (R SQ (subcutaneous) The only change from	ide Acetate Solution 100 stravenously three times a N to administer) MAY GIVE PER (name of physician). In the previous order was the ster the medication via						
	#4, the facility's med the medication was reancer, but was orde symptoms related to (which was in turn re peritoneal adhesions A review of the February	uary and March 2021 MAR t actually received a total of						
	evidence that the use medication, along with administration and material related to the criterial administration, and a complications, was e	nonitoring requirements of an RN only associated side effects and ever developed on care plan, baseline care plan or the						
	A review of the care	plan revealed the following:						
		resident was admitted on ite in place) for "Potential for						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495227	B. WING		C 06/17/2021			
	ROVIDER OR SUPPLIER	I	73	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION			
F 656	complications at IV in plan only included int site, dressing, and tuinot include any intervand the administratio requirements of the Cone dated 2/25/21 founsteady gait, general environment, medical Interventions include "Administer medicated did not include any in use, and the administrequirements of the Cone dated 3/12/21 (rowspan 2/24/21 with the ostonostomy related to dis Resident fondles with resident was on the Copresence of the ostor interventions related administration and moctreotide. One dated 3/12/21 (rowspan 2/24/21 with a risk for interventions included for "Administer medical administration and moctreotide. One dated 3/12/21 (rowspan 2/24/21 with a risk for interventions included for "Administer medical and "Evaluate medical lab results for possible interventions did not related to the use, and monitoring requirements of the construction of the use, and monitoring requirements."	erventions related to the IV bing management and did rentions related to the use, in and monitoring Octreotide. It is for falls due to alized weakness, new tion side effect." If one dated 2/25/21 to on per physician's order." It terventions related to the tration and monitoring Octreotide. Resident was admitted on my site in place) for "Bowel sease process cancer in ostomy appliances." The Octreotide related to the my. It did not include any to the use, and the onitoring requirements of the esident was admitted on or GI distress) for "G.I. usea/vomiting." It did interventions dated 3/12/21 cations per physician orders ations, diet, environment and the causes." The include any interventions diet administration and	F 656					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021		
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	E	06/1//2021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 656	(Registered Nurse), the Assurance) she stated have been developed medication; and for a been used in the faci was not familiar with, administration and medinitely should have on 6/17/21 at 4:28 P #2 (Administrative St Nursing) she stated the planned. ASM #2 stated the planned. ASM #2 stated the planned and it will be survey. References: (1) A review of the face 2020 Nursing Drug Repages 948-950, Octrosymptoms of carcinos intestinal peptide turn unlabeled uses included intestinal peptide turn unlabeled u	the QA nurse (Quality and that a care plan should diregarding the use of any IV medication that had not lity before, for which the staff and required specific onitoring criteria, there is been a care plan. M in an interview with ASM aff Member, the Director of that it should have been care ated she reviewed Resident was not done. In was provided by the end of accidity's drug book, "Mosby's deference, 33rd Edition" entitle was used for a tumors, vasoactive fors, as well as some ding GI (gastrointestinal) additions, and dumping mation on this medication IV push route was to be minutes. Storage of this mented as storage in the	F	656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 6/17/2021	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		0/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	(PICC), also called a tube that's inserted the and passed through the heart. Very rarely, the your leg. A PICC line the large central vein generally used to give nutrition. A PICC line frequent needle stick irritation to the smalle PICC line requires care complications, includ Information obtained https://www.mayoclin line/about/pac-20468	rally inserted central catheter PICC line, is a long, thin arough a vein in your arm to the larger veins near your e PICC line may be placed in e gives your doctor access to s near the heart. It's e medications or liquid can help avoid the pain of s and reduce the risk of er veins in your arms. A preful care and monitoring for ing infection and blood clots. from hic.org/tests-procedures/picc-748.	F 6	56			
	3/28/12, with the diag cerebrovascular dise mood disorder, deme pressure, atrial fibrilla degeneration. The material Data Set) assessmen with an ARD (Assess 4/12/21, coded Residing paired in ability to a The resident was cod assistance for all are except for eating, whonly. A review of the comprevealed one dated 1 alteration in skin integers.	1/11/20 for "At risk for grity" This care plan ion dated 11/11/20 for					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			1	C 17/2021	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 500 FOREST AVE ICHMOND, VA 23226	,		
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 656	evaluation from the f dated 6/11/21. This "Length: 1.37 cm. W cmEtiology: Press 2Dressings: Medi Dressing - Bordered Further review of the physician's order dat buttocks cleanse with medihoney, cover with A review of the June Administration Recontreatment was not do completed on 6/13/2 On 6/14/21 at 3:29 F conducted with LPN Nurse), the nurse wh #10 on 6/13/21. Wh wound care on 6/13/	al record revealed an acility's wound care provider evaluation documented, /idth 1.39 cm Depth 0.10 ure Ulcer - Stage honey (1). Secondary gauze" clinical record revealed a ed 6/11/21 for "Bilateral n NS (normal saline), apply th boarder gauze" 2021 TAR (Treatment rd) on 6/14/21 revealed this ocumented as being 1.	F	656				
	day. I had three hos family here. I didn't go for itI did not do the if she notified anyone supervisor, the next did not notify anyone done." When asked notified, LPN #3 state Resident #10's care stated that it was not On 6/15/21 at 4:34 F (Administrative Staff and Director of Nursi	pice residents and a lot of get to it. I don't believe I tried e wound care." When asked e (the physician, nurse shift nurse) LPN #3 stated, "I that the wound care was not if anyone should have been ed, "Yes." When asked if plan was followed, LPN #3						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	COMPLETED	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		06/17/20	124
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	00/1//20	12 1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COM	(X5) IPLETION DATE
F 656	Continued From pag provided by the end		F 65	56		
	contains 100% active hydrocolloidal susper of necrotic tissue and Thicker consistency provides more stabil Information obtained	l from ource.com/product/medihone				
	2/8/21. Resident #5 were not limited to: (blockage of pulmon or thrombus 'blood c (inability of the heart adequate gas excha (progressive state of	ary artery by foreign matter lot') (1), respiratory failure and lungs to maintain nge) (2) and dementia mental decline) (3).				
	set) assessment, a 6 with an assessment coded the resident a BIMS (brief interview indicating the resider impaired. MDS Secticoded the resident a bed mobility, transfe personal hygiene an independent and war of MDS Section O-S	Iking did not occur. A review Special treatments, grams: coded the resident as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING			1	C 1 17/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		7300 FORE	DRESS, CITY, STATE, ZIP CODE ST AVE D, VA 23226	1 00/	1772021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	2/13/21, documented falls due to impaired Resident at risk for in bruising due to Rivarusage. INTERVENT medications per phys. The physician orders in part, "Rivaroxaban milligram by mouth in vein thrombosis) projuntiepileptic and neucapsule, give 1 capsule, give 1 capsule for neuralgia. Levoth (6) tablet 25 micrografor hypothyroidism." A review of the MAR	rehensive care plan dated I in part, "FOCUS-At risk for balance/poor coordination. crease bleeding and oxaban (anticoagulant) (4) IONS-Administer	F	556			
	failed to evidence do administration of Riva evening of 2/19/21, 0 the evening of 2/19/22 micrograms in the modern of the evening of 2/19/2 micrograms in the modern of the eview of the nursing 2/20/21 at 1:32 PM, 0 "Resident pronounce" An interview was comply with LPN (licenses asked the purpose of plan, LPN #2 stated, plan of care for the reblanks on the MAR in could mean that the interview of the event	cumentation for the aroxaban 20 milligram in the Gabapentin 300 milligram in 11 and Levothyroxine 25 prining of 2/20/21.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			1	C 17/2021
	ROVIDER OR SUPPLIER			7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226	1 00/	17/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	' '	e 54 cumentation means, LPN #2	F	656			
	stated, "It usually mea it wasn't done."	ans if it wasn't documented,					
	PM with ASM (adminithe director of nursing of the comprehensive "The care plan is indineeds of the resident means if there is blan MAR, ASM #2 stated	ducted on 6/15/21 at 3:45 istrative staff member) #2, g. When asked the purpose care plan, ASM #2 stated, vidualized to the unique ". When asked what it k documentation on the y to prove it was given".					
	of nursing and ASM #	trator, ASM #2, the director #3, the quality consultant, the above concern on					
	ASM (administrative sadministrator and AS) were made aware of 6/15/21 at 4:45 PM.	M #2, the director of nursing,					
	8/2016, documents in	ne Care Plan" policy dated part, "Documentation must e resident's care plan".					
	chosen only after care sequencing of events relationship between	licy dated 12/2016, Care plan interventions are eful data gathering, proper , careful consideration of the the resident's problem areas I relevant clinical decision					
	The same and the s	· · · · · · · · · · · · · · · · · · ·					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED	
		495227	B. WING		C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		1 00/17/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 658 SS=E	Non-Medical Reade Chapman, page 48: (2) Barron's Diction Non-Medical Reade Chapman, page 50: (3) Barron's Diction Non-Medical Reade Chapman, page 15: (4) Lippincott Pocke 2019, Wolters Kluw (5) Lippincott Pocke 2019, Wolters Kluw (6) Lippincott Pocke 2019, Wolters Kluw Services Provided NCFR(s): 483.21(b)(3) Compass Value CFR(s):	ary of Medical Terms for the er, 7th edition, Rothenberg and 2. ary of Medical Terms for the er, 7th edition, Rothenberg and 2. ary of Medical Terms for the er, 7th edition, Rothenberg and 4. er Drug Guide for Nurses, er, page 338. er Drug Guide for Nurses, er, page 168. er Drug Guide for Nurses, er, page 215. Meet Professional Standards 3)(i) prehensive Care Plans led or arranged by the facility, comprehensive care plan, al standards of quality. NT is not met as evidenced rview, clinical record review, view, and in the course of a tion, it was determined that ad to follow professional se for one of 12 residents in	F 656		staff s re	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				C 17/2021
	ROVIDER OR SUPPLIER	ND NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE LICHMOND, VA 23226	1 00/	11/2021
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	ordered by the physical administered it by the order. The findings included Resident #4 was ad 2/24/21 and dischard had the diagnoses of obstruction, peritoned diabetes, morbid obblood pressure. The	m RN (Registered Nurse) as sician; and the LPN me incorrect route without an eincorrect route without eincorrect route eincorrect ro	F	658	related MARs weekly times 4 weeks an monthly times 2 to ensure facility staff following orders and working within the scope of practice. Any identified issues will be immediately corrected. Results be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28 2021.	are ir s will	
	ARD (Assessment I The resident was co- intact in ability to ma resident was coded eating; extensive as dressing, toileting a assistance for hygie 1A. The facility stat physician's order fo	f failed to clarify the r what method of IV eotide was to be administered					
	discharge documen documented, "Start medicationsOctre (micrograms per mi (milliliter) by intrave daily for 30 days" PICC (2) line IV site	taking these eotide (1) 100 mcg/ml lililter) injection. 1 ml nous (IV) route three times Note: The resident had a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 6/17/2021	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		0/17/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 658	(1) According to the fit 2020 Nursing Drug Fit pages 948-950, Octrisymptoms of carcino intestinal peptide tumbe administered via I (intramuscularly). It route may be adminisminutes, or by an intestinal peptide tumbe administered via I (intramuscularly). It route may be adminisminutes, or by an intestinate of 200 milliliters of an over 15 to 30 minute. A review of the physifollowing: On 2/24/21: "Octreo MCG/ML Use 1 ml inday (TID) for cancer. On 3/1/21: "Octreoti MCG/ML Use 1 ml inday for cancer (RN to change from the origithat an RN (Register the medication. This (Licensed Practical Nather medication. On 3/4/21: "Octreoti MCG/ML Use 1 ml inday for GI Fistula (RI change from the previous properties of the properties of	of a specific amount of sified period of time. facility's drug book, Mosby's Reference, 33rd Edition" eotide is used to treat id tumors and vasoactive mors. This medication may V, SQ, or IM was documented that the IV stered via direct IV over 3 ermittent route diluted in 50 in IV fluid and administered ss. cian's orders revealed the tide Acetate Solution 100 itravenously three times a condition administer)." The only inal order was the addition ed Nurse) had to administer	F 65	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	, ,	COMPLETED	
		495227	B. WING		0.0	C 6/ 17/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, 0	0/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658	MCG/ML Use 1 ml in day for GI Fistula (R SQ (subcutaneous) The only change fro ability to also admin subcutaneous route None of the above of infusion method was a review of the phare 2/25/21, 3/11/21 and medication was proved. Further review of the reveal any evidence obtained any clarific which IV route was in the conducted with LPN Nurse). She stated supervisor at the time LPN #11 stated she admission. She stare should be push or poshe just put the order hospital record. She clarified if required poincluded in an order administered the medications and "General Review of facility positions" and "General Review of facility positions" and "General Review of facility positions" and "General Review of facility positions of Clinical Review of Clinical Review of facility positions of Clinical Review of Review o	itide Acetate Solution 100 intravenously three times a in to administer) MAY GIVE PER (name of physician). In the previous order was the ister the medication via orders clarified what IV is to be utilized. In the previous order was the ister the medication via orders clarified what IV is to be utilized. In the previous order was the ister the medication via orders clarified what IV is to be utilized. In the previous order was the provious of the provious order was the provious of the	F 65	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	E	00/1//2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	page 553, was doct the prescriber any r unclear or seems in On 6/17/21 at 4:28 ASM #1 and ASM # Member, the Admin	mentals of Nursing, & Wilkins 5th edition, 2007, umented, "Always clarify with nedication order that is appropriate." PM in a end of day meeting, (2 (Administrative Staff istrator and Director of aware of the findings. No	F 6	58			
	Standards of Practical administered by an Nurse) instead of an ordered by the physical standards of the physical standards of the physical standards of Practical Standards of Standard	f failed to follow Professional ce when an IV medication was LPN (Licensed Practical n RN (Registered Nurse) as sician; and the LPN ne incorrect route without an					
	https://www.practica ter-medication, it wa "Medications You C Licensed Practical I any type of drug thr the state). The LPN in preparation for th IV medication, but t itDifferent employ For some medication at one institution, and you to undergo some	actical nursing (LPN) website alnursing.org/can-lpns-adminis as documented under annot Administer" that, "The Nurse is not permitted to give ough an IV line (depending on may flush a peripheral IV line e Registered Nurse to give an he LPN cannot actually give vers have different regulations. In that you could freely give nother employer may require he type of training before you ster it. RNs are able to give higher risk of unknown					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				C 17/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226	, 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From pag	e 60	F	658			
		medications, while it would fractice for LPNs"					
	A review of the Febru revealed the following	uary and March 2021 MAR g:					
		received a total of 64 doses f these 64 opportunities, 41 y an LPN.					
	administered the mediumes it was administ asked if she was an When asked if she was allowed to administered the medium when she looked up	#2, who was the LPN that dication on 15 of the 41 ered by an LPN. When RN, LPN #2 stated, "No." as aware that only an RN nister the medication, given an's order, she stated that en asked why she dication, LPN #2 stated that the medication, the drug					
	(intramuscularly), so instead of IV, as she could not give a med asked if she called the could be given IM an administration of the had not. LPN #2 star (from reading the druge)	at it could be given IM she administered it IM was an LPN and an LPN ication via IV route. When he physician to clarify if it d to obtain an order for IM medication, she stated she ted, "From my understanding ng book), it could be given					
	time I gave it, I gave education and trainin medication, LPN #2 s provided any training administering this me I was not familiar with the medication provided.	IM over 3 minutes. Every it IM." When asked about g for administering this stated that she was not or education for edication, but that "It was one n." When asked how was ded by the pharmacy, LPN in a vial. It did not need to					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		L TOENTIEICATION NITIMBED:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495227	B. WING		C 06/17/2021			
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		0/11/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 658	#4, the Medical Direct medication has never before.\ On 6/16/21 at 3:18 Producted with OSM Pharmacy. She state any implications for on the second of the facility of the facility of the second of the facility of the second of the facility of the	AM in an interview with ASM ctor, he stated that this r been used in this facility M an interview was #15, the Director of ed that she "Could not find giving the medication IM. sues. However, given IM it is or SQ." y's drug book, "Mosby's 2020 nce, 33rd Edition" pages tion on this medication IV push route was to be minutes. The information inistering via IM route did not e over 3 minutes. The IM Reconstitute with diluent eal region, rotate injection the form provided by the I by the physician. M in an interview with ASM he did not know how all the hinistered this medication did ASM #2 stated that "There te and time unknown) where ed and the nurse obtained an M." ASM #2 stated, "She attement from the physician ovided by the end of survey]." ever reflected this and ASM ysician should have been	F 65					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING				C 17/2021	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		7300	FOREST AVE HMOND, VA 23226	1 00	11/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 658	not provide any mea was provided at each order was changed of IV or SQ. It could not if any, the medication and which times, if a administered via SQ 3/24/21, as it was on RN had to administe medication was administered in a subject of the medication was administered in IV or SQ rottle total, 15 different I medication, at least subject on the medication, at least subject on the interval in the i	at the March 2021 MAR did ans to document which route an administration, when the an 3/13/21 to administer via at be determined which times, an was administered via IV, any, the medication was between 3/13/21 and adered for either route, but, an ar it. Of the 31 times the anistered after this order arough 3/24/21 allowing for aute, an LPN administered anes. PN's administered this and of which were identified as ance that the physician was are administering the	F	658				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	IPLE CONS	TRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			1	C 17/2021	
	ROVIDER OR SUPPLIER	1		7300 FO	ADDRESS, CITY, STATE, ZIP CODE REST AVE OND, VA 23226	1 06/	17/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 658	required time frames administering the me label THREE (3) time right medication, right method (route) of ad medication17. For or otherwise unavailathe pass, the MAR medication18. If a given at a time other individual administer and circle the MAR sand dose" A review of the facility special Situations - Underwise documented, "Medicathe nursing facility medispensing from the situation may be due temporarily out of steed drug recall, manufacting facility must make exmedications are availeach resident. A. The Call or notify nursing product(s) is/are una shall: 1) Notify the at situation and explain expected availability	orders, including any7. The individual dication must check the es to verify the right resident, at dosage, right time and right ministration before giving the residents not in their rooms able to receive medication on may be "flagged." After cation pass, the nurse will resident to administer the drug is withheld, refused, or than the scheduled time, the ing the medication shall initial pace provided for that drug y policy, "Miscellaneous Jnavailable Medications" ations used by residents in ay be unavailable for pharmacy on occasion. This to the pharmacy being ock of a particular product, a turer's shortage of an mation may be permanent mo longer being made. The very effort to ensure that lable to meet the needs of the pharmacy staff shall: 1) staff that the ordered vailableB. Nursing staff tending physician of the	F	558				
	the nurse should not	om the attending physician, ify the nursing supervisor ty Medical Director for orders						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	493221	B. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	06/	17/2021
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		7:	300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	cancel/discontinue th medications. 3) Notif replacement order."	e 64 Obtain a new order and e order for the non-available by the pharmacy of the n was provided by the end of	F	658			
	2020 Nursing Drug R pages 948-950, Octre symptoms of carcinoi intestinal peptide tum unlabeled uses includifistulas, diarrheal con syndrome. The information documented that the administered over 3 medication was documented to the period of the period of the period of the page 1 medication of the period of the peri	d tumors, vasoactive ors, as well as some ding GI (gastrointestinal) ditions, and dumping mation on this medication IV push route was to be minutes. Storage of this mented as storage in the ned vials or at room veeks, protected from light. vas documented, including is included decreased effect red monitoring of glucose ally inserted central catheter PICC line, is a long, thin prough a vein in your arm					
	heart. Very rarely, the your leg. A PICC line the large central vein generally used to give nutrition. A PICC line	to the larger veins near your PICC line may be placed in gives your doctor access to s near the heart. It's e medications or liquid can help avoid the pain of s and reduce the risk of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			1	C 17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 658 F 684 SS=E	PICC line requires ca complications, includi Information obtained https://www.mayoclin line/about/pac-20468 Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profepractice, the comprehacare plan, and the residents receives accordance with profepractice, the comprehacare plan, and the residents received accordance with profepractice, the comprehacare plan, and the residents received accordance with profepractice, the comprehacare plan, and the residents received accordance with profepractice, the comprehacare plan, and the residents received accordance with profepractice, the comprehacare plan, and the residents received accordance with profepractice, the comprehacare plan, and the residents received accordance with profepractice, the comprehacare plan, and the residents received accordance with profepractice, the comprehaction of the profession of t	r veins in your arms. A reful care and monitoring for ng infection and blood clots. from ic.org/tests-procedures/picc- 748 are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of iensive person-centered		658	 Residents #4 and #5 no longer resin the facility. All residents have the potential to longer. 		7/28/21	
	care in accordance w practice, and the com- care plan for two of 1 sample, (Residents # The facility staff failed ordered for Resident	I to administer Octreotide as #4 and failed to administer medications to Resident #5			affected by this alleged deficient practic 3. DON or designee will educate all nurses on completing MAR documentation daily, following orders, a ensuring that they practice within their scope of practice. 4. DON or designee will randomly au MARs weekly times 4 weeks and mont times 2 to ensure timely documentation medication is administered as ordered, correct times, and by appropriate staff. Any identified issues will be immediate corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.	and dit hly n, at		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY	
		495227	B. WING _			1	C /17/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		1 00/	11/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	1. Resident #4 was a 2/24/21 and discharg had the diagnoses of obstruction, peritoned diabetes, morbid obe blood pressure. The Data Set) was an Adr ARD (Assessment Rother resident was cool intact in ability to make resident was coded a eating; extensive ass	admitted to the facility on ed on 3/24/21. The resident but not limited to intestinal al adhesions, anal cancer, sity, diverticulosis, and high most recent MDS (Minimum mission assessment with an eference Date) of 3/2/21. Ited as being cognitively are daily life decisions. The is requiring total care for istance for transfers, d bathing; and limited	Fé	684	5. Date of compliance will be July 28 2021.	,	
	discharge document documented, "Start to medicationsOctrec (micrograms per milli (milliliter) by intraveno	aking these tide (1) 100 mcg/ml					
	following: On 2/24/21: "Octreon MCG/ML Use 1 ml in day (TID) for cancer." On 3/1/21: "Octreotic	de Acetate Solution 100					
	day for cancer (RN to	travenously three times a administer)." The only nal order was the addition ed Nurse) had to administer meant that an LPN					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	the medication. On 3/4/21: "Octroom MCG/ML Use 1 ml in day for GI Fistula (For change from the preson of diagnosis as to we given. Note: On 6/16/21 at ASM #4, the facility that the medication for cancer, but was GI symptoms relate ostomy (which was obstruction, periton cancer.) On 3/13/21: Octroom MCG/ML Use 1 ml in day for GI Fistula (Fis SQ (subcutaneous)) The only change from ability to also admining subcutaneous routed.	Nurse) could not administer tide Acetate Solution 100 ntravenously three times a RN to administer)." The only evious order was the change thy the medication was being 11:44 AM in an interview with s medical director, he stated was not being administered ordered to treat the resident's d to a recently acquired in turn related to intestinal eal adhesions and anal tide Acetate Solution 100 ntravenously three times a RN to administer) MAY GIVE PER (name of physician). In the previous order was the ister the medication via	F	684	,		
	On 2/26/21 at 6:00 was not administered notes documented, However, as the me	AM, the dose of Octreotide ed. A review of the nurses "pending pharmacy deliver." edication was delivered at 1, it was available to be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED	
		495227	B. WING		C		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		6/17/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From pag		F 68	34			
	March 2021:						
	1. Missing document	ation:					
	6:00 AM and 10:00 F 3/10/21 at 2:00 PM, initialed as given, an not given for some redocumenting this add. There were no support this administration. On 6/16/21 at 4:30 F #2, (Administrative S Nursing, she stated to determine if they gave	ministration was left blank. Orting nurses notes regarding M in an interview with ASM Ottaff Member), the Director of hat "If there are holes I can't re it are not." When asked he MAR mean, she stated,					
	Improper adminis credentials:	tration route / staff					
	A review of the Febru revealed the followin	uary and March 2021 MAR g:					
		received a total of 64 doses f these 64 opportunities, 41 y an LPN.					
	administered the me	M an interview was #2, who was the LPN that dication on 15 of the 41 ered by an LPN. When					

PRINTED: 08/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			l	C 17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226	DE	1 001	11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 684	asked if she was awa allowed to administer route and physician's was aware. When as it, she stated that who medication, the drug could be given IM (in administered it IM ins LPN and an LPN could be for IM, she stated she "From my understand book), it could be given over 3 minutes. Ever When asked about even administering this mewas not provided any administering this mewas not familiar with the medication provides tated, "In a liquid in mixed." Note: A review of the "Mosby's 2020 Nursin Edition" pages 948-9 medication document was to be administering this mewas to be administering	RN, she stated, "No." When are that only an RN was the medication, given the order, she stated that she sked why she administered en she looked up the book documented that it tramuscularly), so she stead of IV, as she was an Id not give a medication via d if she called the physician given IM and get an order e had not. She stated, ding (from reading the drug en both ways. I gave it IM by time I gave it, I gave it IM by time I gave it, I gave it IM by time I gave it, I gave it IM by time I gave it, I gave it IM by the stated that she of training or education for edication, but that "It was one in." When asked how was led by the pharmacy, she a vial. It did not need to be a facility's drug book, ing Drug Reference, 33rd 50, the information on this ted that the IV push route led over 3 minutes. The ted for administering via IM int it had to be over 3	F6	584				

Facility ID: VA0270

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			I	C 17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DDE	1 00	11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 684	other LPNs who admit (IV or IM or SQ). So one incident (date and doctor was notified an order to administer IM awaiting for a statem (which was never produced that the physic aware of all the other It was also noted that not provide any mean was provided at each order was changed of IV or SQ. It could not if any, the medication and which times, if an administered via SQ, 3/24/21, as it was order was administered via SQ, 3/24/21, as it was order was admit change on 3/13/21 the either an IV or SQ roothe medication was admit change on 3/13/21 the medication, at least 9 not being facility staff. There was no eviden notified that LPNs we medication instead or one LPN (LPN #2) all administration to IM woccasions.	ne did not know how all the inistered this medication did he stated that "There was d time unknown) where the nd the nurse obtained an M." She stated she was ent from the physician ovided by the end of survey). Ever reflected this and she cian should have been made times. It the March 2021 MAR did not be determined which route administration, when the notion of administration was administered via IV, my, the medication was between 3/13/21 and dered for either route, but, and it. Of the 31 times the mistered after this order rough 3/24/21 allowing for oute, an LPN administered hes. PN's administered this of which were identified as a few the physician was are administering the for RN, and that at least	F	584				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	5071772021	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	e 71	F 6	84			
	Related policies:						
	Medications" docum administered in a sa prescribed1. Only permitted by this stat document the admin do so3. Medicatio accordance with the required time frames administering the melabel THREE (3) time right medication, right medication, right medication17. For or otherwise unavail the pass, the MAR in completing the medication to the missed medication18. If a given at a time other individual administeri	ty policy, "Administering ented, "Medications shall be fe and timely manner, and as a persons licensed or the to prepare, administer and istration of medications may must be administered in orders, including any s7. The individual edication must check the est overify the right resident, and the dosage, right time and right ministration before giving the residents not in their rooms able to receive medication on may be "flagged." After cation pass, the nurse will resident to administer the drug is withheld, refused, or than the scheduled time, the ing the medication shall initial space provided for that drug					
	References:						
	2020 Nursing Drug F pages 948-950, Octi symptoms of carcino intestinal peptide tur unlabeled uses inclu fistulas, diarrheal co	acility's drug book, "Mosby's Reference, 33rd Edition" reotide was used for oid tumors, vasoactive nors, as well as some ding GI (gastrointestinal) nditions, and dumping rmation on this medication					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING			1	C 1 17/2021	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			1 06/	17/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 684	administered over 3 medication was door refrigerator for unoptemperature up to 2 Multiple side effects diarrhea. Interaction of insulin which requievels. (2) PICC - A peripher (PICC), also called a tube that's inserted than and passed through heart. Very rarely, theyour leg. A PICC line the large central veing generally used to give nutrition. A PICC line frequent needle stick irritation to the small PICC line requires of complications, includinformation obtained.	e IV push route was to be minutes. Storage of this umented as storage in the ened vials or at room weeks, protected from light. was documented, including as included decreased effect tired monitoring of glucose arally inserted central catheter a PICC line, is a long, thin hrough a vein in your arm to the larger veins near your are PICC line may be placed in a gives your doctor access to as near the heart. It's we medications or liquid a can help avoid the pain of as and reduce the risk of the re veins in your arms. A pareful care and monitoring for ding infection and blood clots. If from a finic.org/tests-procedures/picc-8748	F	584				
	2/8/21. Resident #5 were not limited to: (blockage of pulmon or thrombus 'blood of	admitted to the facility on 's diagnoses included but pulmonary embolus ary artery by foreign matter clot') (1), respiratory failure and lungs to maintain						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	495227	B. WING _				C 17/2021
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AN	D NURSING CENTER		STREET ADDRESS, CIT 7300 FOREST AVE RICHMOND, VA 233		1 00	11/2021
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
(progressive state of Resident #5's most reset) assessment, a 5 with an assessment reduced the resident as BIMS (brief interview indicating the resident impaired. MDS Section coded the resident as bed mobility, transfer personal hygiene and coded as independent not occur. A review treatments, procedure resident as receiving A review of Resident plan dated 2/13/21, do "FOCUS-At risk for fatablance/poor coording increase bleeding and Rivaroxaban (anticoal INTERVENTIONS-Act physician orders." The physician orders in part, "Rivaroxaban milligram by mouth in vein thrombosis) proper (antiepileptic and neucapsule, give 1 capsule for neuralgia. Levoth (6) tablet 25 micrograf for hypothyroidism. A review of Resident	nge) (2) and dementia mental decline) (3). ecent MDS (minimum data day admission assessment, reference date of 2/13/21, as scoring 04 out of 15 on the for mental status) score, at was severely cognitively on G- Functional Status: as extensive assistance with statistically in the statistical material mate	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			06/1	; 7/2021		
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE	, 00/.			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B	I	(X5) COMPLETION DATE		
F 684	evening of 2/19/21, Gethe evening of 2/19/2 micrograms in the mode of 2/20/21 at 1:32 PM, of "Resident pronounced." An interview was con PM with LPN (licensed asked what blanks or stated, "It could mean [medications] weren't weren't given." When documentation means means if it wasn't documenting medicated, "Yes, the nurse of the director of nursing means if there is bland MAR, ASM #2 stated means there is no was a SM #1, the administ of nursing and ASM #4.	cumentation for the aroxaban 20 milligram in the babapentin 300 milligram in 1 and Levothyroxine 25 prining of 2/20/21. In g progress notes dated documented in part, d at 1:32 PM." In ducted on 6/14/21 at 1:53 and practical nurse) #2. When in the MAR mean, LPN #2 in that the meds documented or that they in asked what blank is, LPN #2 stated, "It usually sumented, it wasn't done." are is responsible for the ising administration, LPN #2 is responsible". In ducted on 6/15/21 at 3:45 istrative staff member) #2, g. When asked what it is documentation on the prove it was given. It was given on the guality consultant, the above concern on	F6	584					
	administrator and AS	M #2, the director of nursing, the above concern on							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495227	B. WING _			C 06/17/2021
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	dated 12/2012, doc must be administer orders, including an drug is withheld, ref than the scheduled administering the m circle the MAR space dose." No further informati References: (1) Barron's Diction Non-Medical Reade Chapman, page 48. (2) Barron's Diction Non-Medical Reade Chapman, page 50. (3) Barron's Diction Non-Medical Reade Chapman, page 15. (4) Lippincott Pocke 2019, Wolters Kluw	inistering Medications" policy sumented in part, "Medications and in accordance with the y required time frame. If a rused or given at a time other time, the individual addication shall initial and one provided for that drug and on was provided. The er, 7th edition, Rothenberg and 2. The er, 7th edition, Rothenberg and 2. The er, 7th edition, Rothenberg and 2. The er, 7th edition, Rothenberg and 3. The er, 7th edition, Rothenberg and 4. The Drug Guide for Nurses, er, page 338.	F	684		
F 686 SS=D	2019, Wolters Kluw (6) Lippincott Pocke 2019, Wolters Kluw Treatment/Svcs to I CFR(s): 483.25(b)(1) \$483.25(b)(1) Press Based on the compresident, the facility (i) A resident receiv	et Drug Guide for Nurses, er, page 215. Prevent/Heal Pressure Ulcer I)(i)(ii) egrity sure ulcers. rehensive assessment of a	F	586		7/28/21

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				C 17/2021	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 7300 FOREST AVE RICHMOND, VA 23226		<u> </u>	1772021	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 686	pressure ulcers ar ulcers unless the idemonstrates that (ii) A resident with necessary treatme with professional spromote healing, new ulcers from d This REQUIREME by: Based on staff int facility document incomplaint investig the facility staff fait reatment and serpressure ulcer for survey sample, Resurvey sa	and does not develop pressure individual's clinical condition of they were unavoidable; and pressure ulcers receives ent and services, consistent estandards of practice, to prevent infection and prevent eveloping. ENT is not met as evidenced erview, clinical record review, clinical record review, eview, and in the course of a lation, it was determined that led to provide the necessary vices to promote healing of a lone of 12 residents in the lesident #10. Iteld to provide wound care as evidence that led to provide wound care as evident #10. Iteld to provide wound care as evident #10's 6/13/21. Ide: Sure Ulcer Advisory Panel 2 pressure ulcer as: Dess of dermis presenting as a rewith a red pink wound bed, any also present as an intact or turn-filled blister.	F 6	1. Resident #10 continue facility and is receiving pretreatments for pressure ulce. 2. All residents with preshave the potential to be affalleged deficient practice. 3. DON or designee will nurses that treatments must as prescribed and that TAR documentation must be concept to the pressure ulcer TARs week weeks and monthly times a treatments were delivered and documentation complete identified issues will be impresented. Results will be impresented. Results will be requality Assurance committed and revision x 3 months. 5. Date of compliance with 2021.	scribed cer. sure ulcers fected by this educate all st be delivered mpleted time randomly aud by times 4 to ensure the as prescribed eted. Any mediately eported to the for analys	ed ely. dit nat d		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING				C / 17/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			1112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 686	*Bruising indicates s Resident #10 was ad 3/28/12, with the diagonal cerebrovascular disemood disorder, demonder and pressure, atrial fibrilla degeneration. The mote of the pressure at the pressure at the pressure at the pressure, atrial fibrilla degeneration. The mote of the pressure at the pressure	dmitted to the facility on gnoses of but not limited to ease, stroke, contracture, entia, depression, high blood ation, and lumbar disc nost recent MDS (Minimum nt, a quarterly assessment sment Reference Date) of dent #10 as moderately make daily life decisions. ded as requiring extensive eas of activities of daily living, eich required supervision all record revealed a nurse's east of activities of daily living, eich required supervision all record revealed a nurse's east of activities of daily living, eich required supervision all record revealed a nurse's east of activities of daily living, eich required supervision all record revealed a nurse's east of activities of daily living, eich required supervision all record revealed a nurse's east of activities of daily living, eich required supervision all record revealed a nurse is east of activities of daily living, eich required supervision all record revealed a nurse is east of activities of daily living, eich required supervision all record revealed a nurse is east of activities of daily living, eich required supervision all record revealed a nurse is east of activities of daily living, eich required supervision all record revealed a nurse is east of activities of daily living, eich required supervision all record revealed a nurse is east of activities of daily living, eich required supervision. All record revealed a nurse is east of activities of daily living, eich required supervision.	F	586				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY MPLETED
		495227	B. WING _			C 06/17/2021
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		3071772021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	this treatment was completed on 6/13/ On 6/14/21 at 3:29 conducted with LPN Nurse), the nurse w #10 on 6/13/21. W wound care on 6/13 do the wound care. day. I had 3 hospic here. I didn't get to itI did not do the she notified anyone supervisor, the nex did not notify anyor done." A review of the com revealed one dated alteration in skin int included an intervel "Treatment as orde On 6/15/21 at 4:34 (Administrative Stat and Director of Nuraware of the finding provided by the end COMPLAINT DEFINATION COMPLAINT COMP	prod) for Resident #10 revealed and documented as being 21. PM, an interview was Was Was (Licensed Practical tho was assigned to Resident then asked if she did the Was a really, really busy the residents and a lot of family wit. I don't believe I tried for wound care." When asked if the physician, nurse that the wound care was not was a really to the physician of the that the wound care was not was a shift nurse), LPN #3 stated, "I was a really really busy the residents and a lot of family wound care." When asked if the physician, nurse that the wound care was not was a shift nurse), LPN #3 stated, "I was that the wound care plan 11/11/20 for "At risk for egrity" This care plan 11/11/20 for "At risk for egrity" This care plan 11/11/20 for red." PM, ASM #1 and ASM #2 of Member - the Administrator sing, respectively) were made as. No further information was at of the survey.	F 6	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 06/17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 689 SS=D	y-gel-wound-burn-dre Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensi §483.25(d)(1) The re as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on clinical rec review and staff inter facility staff failed to p and failed to ensure a accident hazards to p 12 residents in the su The facility staff failed Resident # 2 while th appointment on 04/22 diagnoses, including legal blindness, and v assessed as moderal making daily decision	from urce.com/product/medihone essing ards/Supervision/Devices (2) . ure that - sident environment remains exards as is possible; and esident receives adequate estance devices to prevent is not met as evidenced cord review, facility document view, it was determined that erovide adequate supervision an environment free of erevent accidents for one of erevent accidents for one of erevent accident # 2. It to ensure supervision of the resident was at a urology 2/2021. Resident #2, with intellectual disabilities [1],	F 68	86	ervision at ervision at e potential eficient cate ward eck for nents and is in place. omly audit ments thly times		
		he appointment and without was left unattended in the		supervision have it lined up and confirmed. Any identified issues immediately corrected. Results reported to Quality Assurance of for analysis and revision x 3 modern and the supervision between the	s will be will be committee onths.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _				C / 17/2021	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		1 00/	17/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 689	Resident # 2 was ad diagnoses that includintellectual disabilitie loss and benign prosiders and benign and admission as (assessment referenceded Resident # 2 abrief interview for mediagnosition for making 1 was coded as requience staff member for The "Skilled Nursing Resident # 2 dated 0 Hospital] documente Information. Follow upon and the facility's unit 2 diagram, "Friday, April 16. 202 Resident # 2] on 4-2. "Thursday, April 16. 202 Resident # 2] on 4-2. "Thursday, April 22. 1/2:30pm [Urology Of Transport Company." The [Name of Urology 2 dated 04/22/2021 of 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.	mitted to the facility with ded but were not limited to: s [1], legal blindness, vision static hyperplasia [2]. recent MDS (minimum data assessment with an ARD ce date) of 04/21/2021, as scoring a 6 [six] on the ental status (BIMS) of a score moderately impaired of daily decisions. Resident # siring extensive assistance of activities of daily living. Facility Transfer Report" for 14/15/2021 from [Name of d in part, "Follow-up up with [Name of Urology. 2:30 pm [Name of Doctor]."	F6	689	2021.			
	impressions indicating the urologist on 04/2 On 06/14/2021 at 1:2 conducted with OSM social worker regard	ng Resident # 2 was seen by						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495227	B. WING _			C 06/17/2021
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DE	00/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	DATE
F 689	When asked to descresident that has an facility, OSM # 8 states, someone from the Iresponsible party] a accompany the residence of the company that the company the company the company the company that the company the company that the comp	ribe the procedure for a appointment outside the ted, "After the appointment is the unit will contact the RP and ask who going to lent." In regard to Resident # I was brought in after he was prology office called us [Resident # 2] couldn't be the was there with him. From the exast manager from the was unable to the was a followed by the exast here with him. From the exast manager from the was a formal from the exast manager from the was a formal from the exast manager from the exast manager from the exast manager from the was a formal from the exast manager from the exast	F	589		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 06/1	7/2021	
	ROVIDER OR SUPPLIER	AND NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE		-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE	
F 689	already here and it appointment I do the calendar for the was seven days on the ward clerk has time also call the RP [research know when and withem if they want to us set up transport are going to the appointment, LPN (certified nursing a specified nursing a see if they have strappointment, they times in the past." documentation that contacted prior to a that it would be do notes. LPN #5 wanotes for Resident 04/30/2021. After LPN # 5 stated, "T about contacting the concern that Residurology appointment unaccompanied, Lhave been contact met the resident at On 06/16/2021 at a [administrative statia administrator and were made aware."	sportation. If the resident is is a new order for an ne same thing, put it on my and clerk and I go back five to calendar as a reminder so the et to set up transportation. I esponsible party] and let them nere the appointment and ask to transport the resident or have ration. I also ask the RP if they repointment, most of the time dent at the appointment." Scribe the procedure when the resident at the # 5 stated, "I contact [CNA ssistant) # 3], scheduler, to refer to free up to go to the have been able to do it a few when asked about a resident's RP was an appointment, LPN # 5 stated cumented in the progress asked to review the progress asked to review the progress # 2 dated 04/15/2021 through reviewing the progress noted, here's nothing documented he RP." When informed of the lent # 2 was sent to their and left in the doctor's office PN # 5 stated, "The RP should be and someone should have the office."	F	689				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING				C 17/2021
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226	1 00/	17/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 689	by a limited mental cadaptive behaviors sischedules and routin Intellectual disability 18 and may result froutism or cerebral pacauses, such as lack responsiveness. This from the website: https://www.report.nilctSheet.aspx?csid=1	of disorders characterized apacity and difficulty with uch as managing money, es, or social interactions. originates before the age of om physical causes, such as alsy, or from nonphysical of stimulation and adult is information was obtained the gov/NIHfactsheets/ViewFa	F	689			
F 726 SS=D	statebph.html. Competent Nursing SCFR(s): 483.35(a)(3) §483.35 Nursing Ser The facility must have the appropriate comprovide nursing and practicable physical, well-being of each reresident assessment and considering the rediagnoses of the faci accordance with the at §483.70(e).	vices e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care	F	726			7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			1	2 17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 726	and skill sets necess needs, as identified to assessments, and deserged by the set of th	e the specific competencies ary to care for residents' hrough resident escribed in the plan of care. Ing care includes but is not evaluating, planning and not care plans and responding by of nurse aides. It care plans and responding by to care for residents' hrough resident escribed in the plan of care. It is not met as evidenced by the course of a condition, it was determined that to provide training and e of a medication that hinistration and monitoring that were not familiar with, for in the survey sample; In the survey sample; In the survey only. Facility staff in and were not provided in a care in the survey is the the survey in the survey is the survey is the survey in the survey in the survey is the survey in the survey in the survey in the survey is the survey in the survey in the survey in the survey in	F 7	1. Resident #4 no longer refacility. 2. All residents requiring space that may be unfamiliar thave the potential to be affect alleged deficient practice. 3. DON or designee will edfacility nurses providing spectoresidents to ensure that the understand the provision of alleged to residents to ensure that the understand the provision of alleged care weekly time and monthly times 2 to ensure education/competency. Any issues will be immediately concerned to Quantity will be reported to Quantity will be repor	pecialized to facility stated by this ducate all cialized care. I will be a care. I will facility the ceeiving as 4 weeks are identified by the corrected. I wallty alysis and	aff s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 06/17/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226	CODE	00/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 726	A review of the faciliti Nursing Drug Refere 948-950, the medical of carcinoid tumors, tumors, as well as so GI (gastrointestinal) and dumping syndromedication documer was to be administed of this medication was the refrigerator for untemperature up to 2 Documented side included decreased	cy's drug book, "Mosby's 2020 ence, 33rd Edition" pages tion was used for symptoms vasoactive intestinal peptide ome unlabeled uses including fistulas, diarrheal conditions, me. The information on this sted that the IV push route red over 3 minutes. Storage as documented as storage in nopened vials or at room weeks, protected from light. Cluded diarrhea. Interactions effect of insulin which of glucose levels, which the	F	726			
	2/24/21 and dischard had the diagnoses of obstruction, peritoned diabetes, morbid obed blood pressure. The Data Set) was an Ad ARD (Assessment Rather resident was contact in ability to ma resident was coded eating; extensive assistance for hygien	al record revealed a hospital					
	documented, "Start t	aking these otide (1) 100 mcg/ml					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		495227	B. WING				C 17/2021
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			1772521
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 726	(milliliter) by intraven daily for 30 days"	ous (IV) route three times	F	726			
	following: On 2/24/21: "Octred	ician's orders revealed the stide Acetate Solution 100 htravenously three times a					
	On 3/1/21: "Octreoti MCG/ML Use 1 ml ir day for cancer (RN to change from the orig that an RN (Register the medication. This	de Acetate Solution 100 htravenously three times a o administer)." The only hinal order was the addition ed Nurse) had to administer					
	MCG/ML Use 1 ml ir day for GI Fistula (R change from the pre	de Acetate Solution 100 htravenously three times a N to administer)." The only vious order was the change hy the medication was being					
	MCG/ML Use 1 ml ir day for GI Fistula (R SQ (subcutaneous) The only change from	ide Acetate Solution 100 atravenously three times a N to administer) MAY GIVE PER (name of physician). The previous order was the ster the medication via					
	#4, the facility's med	AM in an interview with ASM ical director, he stated that never been used in this facility					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING				C 17/2021	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		7:	STREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226	1 001	11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 726	not being administer ordered to treat the related to a recently in turn related to interest adhesions and analogous of the conducted with LPN administered the metimes it was administered the was allowed to admit the route and physic she was aware. Whadministered the metimes it was allowed to admit the route and physic she was aware. Whadministered the metimes the looked up book documented the (intramuscularly), so instead of IV, as she could not give a medication could be order for IM administration.	ed that the medication was ed for cancer, but was esident's GI symptoms acquired ostomy, which was stinal obstruction, peritoneal cancer. PM an interview was #2, who was the LPN that dication on 15 of the 41 tered by an LPN. When RN, LPN #2 stated, "No." was aware that only an RN nister the medication, given ian's order, she stated that en asked why she dication, LPN #2 stated that the medication, the drug at it could be given IM she administered it IM was an LPN and an LPN lication via IV route." When the physician to clarify if the given IM and to obtain an irration, LPN #2 stated she	F	726				
	(from reading the druboth ways. I gave it time I gave it, I gave education and training medication, she state any training or education, but that with." On 6/16/21 at 3:00 F conducted with RN (nurse (Quality Impro	ted, "From my understanding ag book), it could be given IM over 3 minutes. Every it IM." When asked about ag for administering this ed that she was not provided ation for administering this "It was one I was not familiar PM an interview was registered nurse) #2, the QA vement). She stated that "It rovided. RN #2 stated that "It						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			1	C 17/2021		
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226)E				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE		
F 726	about side effects, whave to check, like the inserted central cather how to push - time and administer - and that heard that an LPN ac should not have administer to can give it. She show make sure it could be up and saw what way to push, but you wou given IM. I would have the same formulating gave the medication was not provided eduit up and read it. The (education). You would the medication provide with that formulation, knew it had to be via the conducted with RN # stated that she was retime of this resident, actually had one at the training and in-service did not locate any every provided for the use	dication], you need to know hy it is being used, what you he PICC [peripherally eter] line, etc., how often, and duration. Only an RN can was in the order. I just diministered it. An LPN inistered it. If the order was be given IM or SQ an LPN had have called the doctor to be given that way. I looked it way it could be given, how long lid need a doctors order to be we to look in the book to see on can be given IV or IM. I honce. I did the IV push. I had be a processed on the could be more and training. I looked be should be more all did have to check to see if the ded can be given that route Reading the information I IV push over 3 minutes."	F 7	726					
	for a medication that facility before and ha monitoring requireme should have been pro	had never been used in the d specific administration and ents, training and education							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING				C 17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226	1 001	11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE	
F 726	Continued From page	e 89	F	726				
	needed based on the populationFacility a competency evaluation hire, annually, and as on the facility assess. The policy did not speneeded based on an that were unusual or normal resident needstaff. On 6/17/21 at 9:52 A (Administrative Staff and Director of Nursi	taff development and . Specialized skills or training resident and resident-specific ons will be conducted upon s deemed necessary based ment" ecifically address training as individual resident's needs different from the everyday is encountered by facility M, ASM #1 and ASM #2 Member, the Administrator ng, respectively) were made . No further information was						
	References:							
	tumors. Information obtained	to treat symptoms of vasoactive intestinal peptide from Mosby's 2020 Nursing d Edition" pages 948-950.						
	(PICC), also called a tube that's inserted the and passed through the heart. Very rarely, the your leg. A PICC line the large central vein generally used to give	rally inserted central catheter PICC line, is a long, thin brough a vein in your arm to the larger veins near your be PICC line may be placed in be gives your doctor access to s near the heart. It's be medications or liquid can help avoid the pain of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C		
NAME OF P	ROVIDER OR SUPPLIER	433221	D. Willo	STREET ADDRESS, CITY, STATE, ZIP CO	DDF	06/17/2021		
	RT REHABILITATION AN	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 726	irritation to the smalle PICC line requires ca complications, includi Information obtained https://www.mayoclin line/about/pac-20468	s and reduce the risk of er veins in your arms. A reful care and monitoring for ing infection and blood clots. from ic.org/tests-procedures/picc-		726 755		7/28/21		
SS=D	CFR(s): 483.45(a)(b) §483.45 Pharmacy S The facility must providrugs and biologicals them under an agree §483.70(g). The facil personnel to administ permits, but only und a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accur dispensing, and admibiologicals) to meet the service of the provision of t	ervices ride routine and emergency to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident. consultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of n of all controlled drugs in						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			06/1) 17/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/	17/2021	
WESTBOR	T DELIABILITATION AND	D NUDOING CENTED		7300 FOREST AVE				
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE	
F 755	Continued From page	91	F 7	55				
	order and that an acc is maintained and per This REQUIREMENT by: Based on staff interv review, clinical record a complaint investiga the facility staff failed	is not met as evidenced iew, facility document I review, and in the course of tion, it was determined that to ensure a medication was		Resident #4 no longer resid facility. All residents prescribed IV medications requiring RN admin	istratior	n		
	The facility staff failed prescribed medication	ration for one of 12 by sample; Resident #4. If to ensure the physician on Octreotide was available on admission on 2/24/21 for		have the potential to be affected alleged deficient practice. 3. DON or designee will educa admissions staff and nurse mandon reviewing medication orders admission to the facility and ensipharmacy can fill prescribed med. 4. DON or designee will audit admissions orders and MARs we	ate all agemer prior to uring dication new	nt		
	had the diagnoses of obstruction, peritonea diabetes, morbid obe blood pressure. The Data Set) assessmer with an ARD (Assess 3/2/21, coded Reside ability to make daily li was coded as requiring extensive assistance	nitted to the facility on ed on 3/24/21. The resident but not limited to intestinal al adhesions, anal cancer, sity, diverticulosis, and high most recent MDS (Minimum III, an admission assessment ment Reference Date) of nt # 4 cognitively intact in fe decisions. The residenting total care for eating; for transfers, dressing, and limited assistance for		times 4 weeks and monthly time ensure medication has been deli required. Any identified issues wimmediately corrected. Results via reported to Quality Assurance of for analysis and revision x 3 mor 5. Date of compliance will be 3 2021.	es 2 to ivered a vill be will be ommitte onths.	ee		
	A review of the clinical discharge document documented, "Start ta							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG	((X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 06/17/2021	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DE	00/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIAT	DATE.	
F 755	medicationsOctred (micrograms per milli (milliliter) by intraven daily for 30 days" I PICC (2) line IV site. A review of the physi order dated 2/24/21 ft Solution 100 MCG/M three times a day (TI A review of the Febru Administration Recommedication was not at On 2/24/21 at 10:00 notes documented "at On 2/25/21 at 6:00 A notes documented "at A review of the pharm documented the medical medication that the pastock. OSM #15 statemedication that the pastock. OSM #15 statemedication was unable timeWe had to ord Due to some challent received the medication that medication that the parmacist was unable timeWe had to ord Due to some challent received the medication the medication that medication the medication that the parmacist was unable timeWe had to ord Due to some challent received the medication that medication the medication that the medication that the parmacist was unable time	otide (1) 100 mcg/ml diliter) injection. 1 ml ous (IV) route three times Note: The resident had a cian's orders revealed an for "Octreotide Acetate IL Use 1 ml intravenously D) for cancer." diary 2021 MAR (Medication rd) documented that the administered as follows: PM. A review of the nurses awaiting on pharmacy." M. A review of the nurses awaiting on order." macy manifest dated 2/27/21, dication was not delivered to 21 at 11:00 AM. M an interview was #15, the Director of red that Octreotide was not a charmacy routinely kept in red that, We received the t 9:13 p.m. on 2/24/21. She	F 7	55			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 06/17/2021		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226	1 00/	1772021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 755	While this interview pharmacy manifest in obtaining and delifacility in a timely manifest in obtaining and delifacility in a timely manifest in obtaining and delifacility in a timely manifest in a t	26/21 at 7:34 PM on 2/26/21. conflicted with the data on the above, it still reflected a delay vering the medication to the anner. PM in an interview with ASM Staff Member), the Director of that "We were initially told but pharmacy had ting it." on was provided by the end of medication was provided by the end of cold tumors, vasoactive mors, as well as some uding GI (gastrointestinal) anditions, and dumping rmation on this medication of IV push route was to be minutes. Storage of this umented as storage in the ened vials or at room weeks, protected from light. Was documented, including as included decreased effect aired monitoring of glucose	F	755				
		erally inserted central catheter a PICC line, is a long, thin						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	06/	17/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	and passed through the heart. Very rarely, the your leg. A PICC line the large central vein: generally used to give nutrition. A PICC line frequent needle stick irritation to the smalle PICC line requires ca complications, includi Information obtained https://www.mayoclin line/about/pac-20468	arough a vein in your arm to the larger veins near your to PICC line may be placed in to gives your doctor access to to se near the heart. It's to medications or liquid to can help avoid the pain of to and reduce the risk of to reful care and monitoring for to ng infection and blood clots. from tic.org/tests-procedures/picc- to the risk of to reful care and monitoring for to ginfection and blood clots. from tic.org/tests-procedures/picc- to the larger veins near your to see the risk of the reful care and monitoring for the larger veins near your to see the larger veins near you	F 7			
F 842 SS=D	(i) A facility may not resident-identifiable to (ii) The facility may reresident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accorprofessional standard	1483.70(i)(1)-(5) Int-identifiable information. Intelease information that is to the public. It lease information that is to an agent only in Intract under which the agent Idisclose the information Interest in the facility itself is permitted Interest information Interest in the information Interest in Inter	F 8	42		7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING_			C 06/17/2021		
	ROVIDER OR SUPPLIER	O NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	DE	00/11/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 842	(iv) Systematically org §483.70(i)(2) The fact all information contain regardless of the form records, except when (i) To the individual, or epresentative where (ii) Required by Law; (iii) For treatment, pay operations, as permit with 45 CFR 164.506 (iv) For public health in eglect, or domestic vactivities, judicial and law enforcement purp purposes, research permedical examiners, for a serious threat to he by and in compliance §483.70(i)(3) The factor record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 years legal age under State §483.70(i)(5) The mere (i) Sufficient information (ii) A record of the research when the second of the research period period of the research period	lity must keep confidential ned in the resident's records, in or storage method of the release isar their resident permitted by applicable law; yment, or health care need by and in compliance stativities, reporting of abuse, violence, health oversight administrative proceedings, noses, organ donation purposes, or to coroners, aneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. Ility must safeguard medical painst loss, destruction, or records must be retained required by State law; or a date of discharge when and in State law; or are after a resident reaches law. Idical record must containate in to identify the resident;	F	342				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			l	C 17/2021	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	E	1 00/	1772021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	FICIENCIES ID PROVIDER'S PLAN OF CORRECTION EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE			
F 842	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 96 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and official control of the services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a complete and accurate clinical record for one of 12 residents in the survey sample, Residents #10. The facility staff failed to document administered treatments for Resident #10 on 6/13/21. The findings include: Resident #10 was admitted to the facility on 8/28/12 and had the diagnoses of but not limited to cerebrovascular disease, stroke, contracture, mood disorder, dementia, depression, high blood pressure, atrial fibrillation, and lumbar disc degeneration. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/12/21. The resident was coded as being moderately mpaired in ability to make daily life decisions. Resident #10 was coded as requiring extensive assistance for all areas of activities of daily living, except for eating, which required supervision only. A review of the June 2021 TAR (Treatment Administration Record) revealed multiple		F8	1. Resident #10 continues to facility and is receiving prescrit reatments for pressure ulcer. 2. All residents with pressure have the potential to be affect alleged deficient practice. 3. DON or designee will edunurses that treatments must be as prescribed and that TAR documentation must be comp. 4. DON or designee will ran pressure ulcer TARs weekly to weeks and monthly times 2 to treatments were delivered as and documentation completed identified issues will be immer corrected. Results will be reported to the process of the present the	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. Resident #10 continues to reside in facility and is receiving prescribed treatments for pressure ulcer. 2. All residents with pressure ulcers have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses that treatments must be delivered as prescribed and that TAR documentation must be completed timely. 4. DON or designee will randomly audit pressure ulcer TARs weekly times 4 weeks and monthly times 2 to ensure that treatments were delivered as prescribed and documentation completed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495227	B. WING		06/17/2021		
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 00/1//2021		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 842	treatments were no provided on 6/13/2 not documented as "Cleanse s/p (suprawater QD (every da"1, 1/2 side rails up reposition due to w deconditioning ever "Bed against the wenvironment every" "Elevate legs when shift." "House Barrier Cre Buttocks/sacrum at PRN Incontinence of "Left palm guard or shift." "Monitor bruising/bl" "Suprapubic cathet" "Wedge to back whishift." On 6/14/21 at 3:29 conducted with LPI Nurse). When asked documentation on the did all the items.	at documented as being 1. The following items were being completed: a pubic) cath (catheter) soap & ay) & PRN (and as needed)." in bed as enablers to turn and eakness related to ry shift." all to promote clutter free shift." up in chair as tolerated every am - Apply To nd Peri Area QS (every shift)	F 843				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		06/17/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 842	and a lot of family he check offsI was be been documented." A review of the facilit Documentation" docuprovided to the reside plan goals, or any chemedical, physical, fur conditions, shall be demedical record" On 6/15/21 at 4:34 P (Administrative Staff and Director of Nursi	y policy, "Charting and umented, "All services ent, progress toward the care anges in the resident's nctional or psychological documented in the resident's M, ASM #1 and ASM #2 Member - the Administrator ng, respectively) were made . No further information was	F8	342			